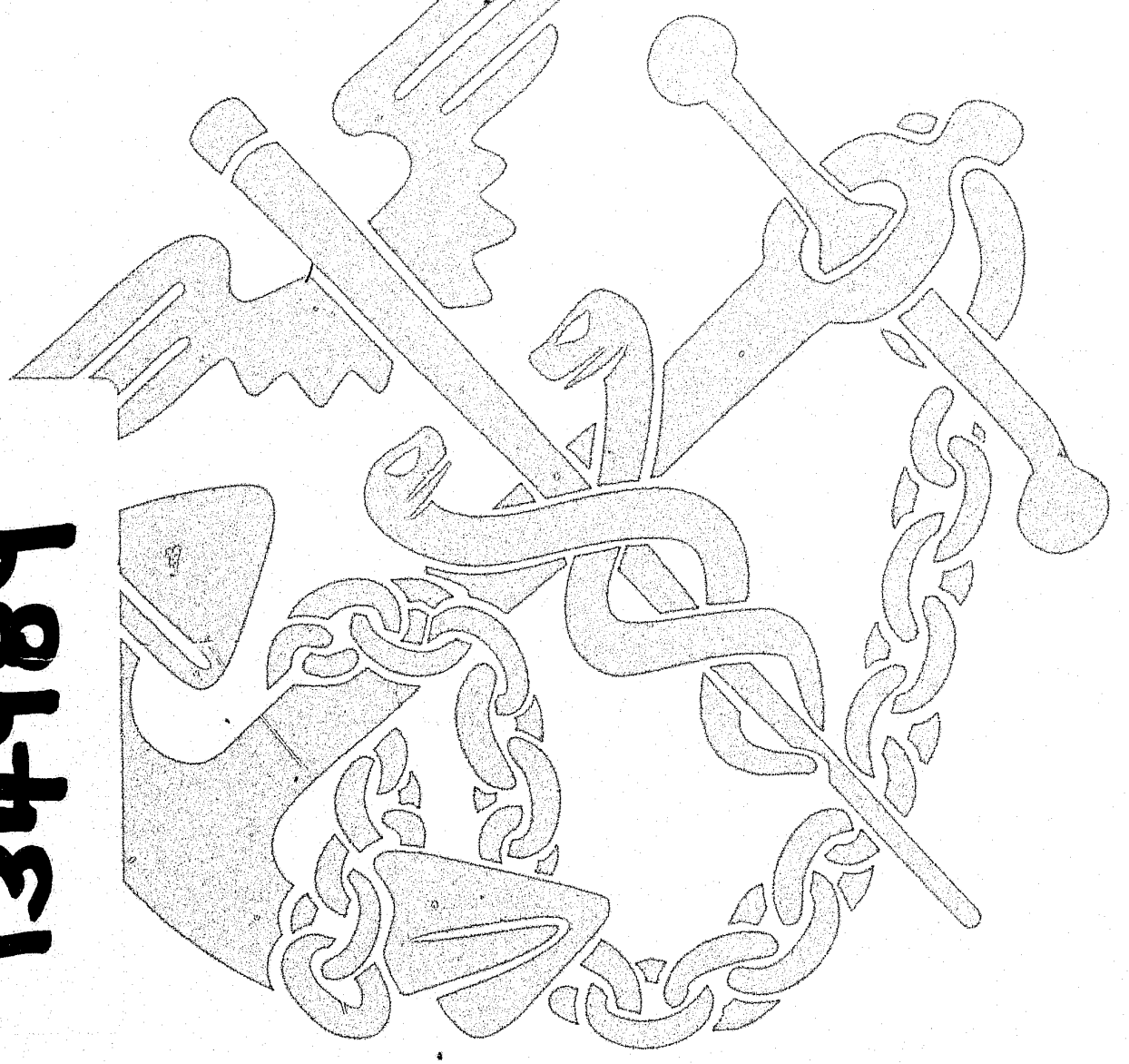
U.S. Department of Justice
National Institute of Corrections

Prison Health Care: Guidelines for the Management of an Adequate Delivery System



National Institute of Corrections

M. Wayne Huggins, Director

Susan M. Hunter, Chief
Prisons Division

John E. Moore, Project Monitor

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Prison Health Care:

Guidelines for the Management of An Adequate Delivery System

B. Jaye Anno, PhD

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LIST OF ABBREVIATIONS

A. Organizations

ABA = American Bar Association
ACA = American Correctional Association
ACHSA = American Correctional Health Services Association
ACLU = American Civil Liberties Union
ADA = American Dental Association
ADA = American Diabetes Association
ALA = American Lung Association
AMA = American Medical Association
AMRA = American Medical Record Association
ANA = American Nurses' Association
APA = American Psychiatric Association
APHA = American Public Health Association
BJS = Bureau of Justice Statistics
CDC = Centers for Disease Control
DEA = Drug Enforcement Agency
EFA = Epilepsy Foundation of America
FBP = Federal Bureau of Prisons
GAO = General Accounting Office
IDOC = Illinois Department of Corrections
IRA = Irish Republican Army
JCAHO = Joint Commission on Accreditation of Healthcare Organizations
JCCMT = Joint Commission on Correctional Manpower and Training
LEAA = Law Enforcement Assistance Administration
NACCJSG = National Advisory Commission on Criminal Justice Standards and Goals
NAIC = National AIDS Information Clearinghouse
NCCD = National Council on Crime and Delinquency
NCCHC = National Commission on Correctional Health Care
NCJRS = National Criminal Justice Reference Service
NCPHSBBR = National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research
NIC = National Institute of Corrections
NIDA = National Institute of Drug Abuse
NIJ = National Institute of Justice
NPDB = National Practitioner Data Bank
NSA = National Sheriffs' Association
OMB = Office of Management and Budget
OSHA = Occupational Safety and Health Administration
TDC = Texas Department of Corrections
TDCJ = Texas Department of Criminal Justice

B. Terms & Titles

ADP = average daily population
ADPS = automatic data processing system
AIDS = acquired immune deficiency syndrome
AZT = zidovudine
CCHP = certified correctional health professional
CHCP = Correctional Health Care Program
CO = correctional officer
COPD = chronic obstructive pulmonary disease
CPI = consumer price index
CPR = cardiopulmonary resuscitation
CPT = Current Procedural Terminology
CQI = continuous quality improvement
CRT = cathode ray tube
CSS&M = contractual services, supplies and materials
CT = computerized tomography
dBA = decibel on the A scale
DDS = doctor of dental surgery
DNA = deoxyribonucleic acid
DOC = department(s) of corrections
DRG = diagnostic-related group
DSM = Diagnostic Statistical Manual
EAP = employee assistance program
EEG = electroencephalogram
EMT = emergency medical technician
ESRD = end stage renal disease
FMIS = financial management information system
FTE = full-time equivalent
FY = fiscal year
HBV = hepatitis B virus
HIV = human immunodeficiency virus
HMO = health maintenance organization
HSD = health services director
H/VAC = heating, ventilation and air conditioning
ICD = International Classification of Diseases
IRB = institutional review board
IV = intravenous
JAMA = Journal of the American Medical Association
KOP = keep-on-person
LOS = length of stay
LPN = licensed practical nurse
LSD = lysergic acid diethylamide
MD = doctor of medicine
MIS = management information system
MMR = measles, mumps and rubella
NP = nurse practitioner
OB/GYN = obstetrics/gynecology

OJT = on-the-job training
OTC = over the counter
PA = physician assistant
PCP = phencyclidine
PhD = doctor of philosophy
POMR = problem oriented medical record
POPS = Project of Older Prisoners
PPD = purified protein derivitive (of tuberculin)
PRO = peer review organization
PPO = preferred provider organization
p.r.n. = *pro re nata* or "as the occasion requires"
PULHES = physical, upper extremities, lower extremities, hearing, eyes, psychiatric
QA = quality assurance
QI = quality improvement
RAM = random access memory
RFP = request for proposal
RM = risk management
RN = registered nurse
RPh = registered pharmacist
SOAP = subjective, objective, assessment, plan
STD = sexually transmitted disease
TB = tuberculosis
UCRS = unit-cost report system
UDA = utilization data system
UHA = unit health authority
UR = utilization review
US = United States
WAIS-R = Wechsler Adult Intelligence Scale-Revised
ZBB = zero based budgeting

PREFACE

Developing a comprehensive reference book on correctional health care was not a simple task. It involved careful thought, much reading, even more writing and the participation of numerous individuals. Some of the chapters were written by others or co-authored with me. Author attribution is shown in a footnote at the beginning of such chapters. Similarly, some of the appendices were reprinted from other sources as indicated. Those chapters and appendices without specific attribution were developed by me.

Writing, editing and compiling this book was both a labor of love and, at times, just sheer labor. I also learned a great deal, cemented relationships with those who worked closely with me on this project, renewed my admiration for correctional health professionals and developed respect for those individuals who earn their living by writing.

Let me make my biases clear. I firmly believe in inmates' right to adequate health care and I am passionate about improving the correctional health profession. I think it is time for those of us involved in this field to stop apologizing for where we work and what we do. Our work embodies the noblest precepts of medicine -- to serve our fellow human beings without regard to anything except their medical needs. We do it not because we can't find other jobs and not because the courts say we have to, but because it is right.

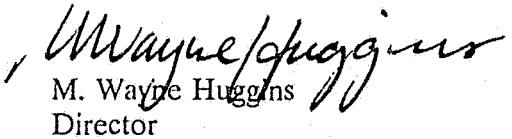
BJA
3/27/91
Chicago

FOREWORD

Few areas aside from overcrowding cause correctional administrators more concern than providing health services for inmates. A perennial problem is how to deliver quality health services to inmates on a timely basis in a cost-effective manner. This problem is exacerbated by the absence of guidance in areas including legal issues, ethical concerns, custody/medical interfaces, staffing issues, special needs inmates, and cost containment.

The National Institute of Corrections (NIC) commissioned the development of this comprehensive reference manual for correctional administrators and correctional health professionals to provide guidance in the provision of health services. The manual reviews the most recent literature and case law on the subject of correctional health care and summarizes the position of national organizations and correctional health care experts on a variety of topics.

This source book will help focus attention on correctional health issues, provide guidance to the field in improving correctional health care delivery, and identify directions for future efforts. It is NIC's belief that improving correctional health care enhances the corrections field as a whole.



M. Wayne Huggins
Director
National Institute of Corrections

October 1991

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Writing is, unquestionably, a solitary activity. My task was made less lonely by the substantial contributions of a number of other people.

First and foremost, I want to thank the members of the editorial advisory board that was established for the project:

Nancy Neveloff Dubler, LLB
Kenneth L. Faiver, MLIR, MPH
Bernard P. Harrison, JD
Walter Y. Quijano, PhD
Nick Pappas
Ronald M. Shansky, MD, MPH
Armond H. Start, MD, MPH

They read and critiqued every word. The combined expertise of these individuals is astounding. They not only gave fully of their knowledge and advice, but also saved me from making potentially embarrassing or inaccurate statements. I am deeply indebted to each of them.

I am grateful as well to my co-authors who contributed to one or more chapters of this book. They include:

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Their special expertise in areas unfamiliar to me was essential in developing a comprehensive book on correctional health care.

The support of John Moore, who served as the National Institute of Corrections (NIC) Project Monitor, was stellar. His belief in this project (and that I would eventually complete it) was unwavering. Also, Nancy Sabanosh of NIC was very helpful in the final editing process.

In addition to the members of the editorial advisory board, there were a host of other experts in correctional health care who reviewed and critiqued one or more chapters. I want to thank the following for their participation and their insightful comments:

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I also want to thank the representatives from the DOCs in Maryland, New York, South Carolina, South Dakota and Vermont who graciously allowed Doctor Walter Quijano to visit their mental health programs as part of the preparation for this book.

I am grateful as well to the representatives from the departments of correction in Louisiana, Michigan, Minnesota, Oregon, Texas and Utah who participated in an NIC-sponsored workshop in November 1990 on managing the chronically ill inmate. Their comments helped crystalize my thinking and gave me a better idea of what DOCs were doing in this area. The assistance of both Roger Smith, D. Crim., and Peg Ritchie of the NIC's National Academy of Corrections was helpful as was the training manual prepared by Mary Millar. Discussions with Ken Peterson, RN and William O'Leary, JD were useful as well.

I made extensive use of library resources in preparing this book beyond what was available at the National Commission on Correctional Health Care's headquarters. Staff at the NIC's Information Center and at the National Criminal Justice Reference Service were very helpful, but I am particularly grateful to Terry Austin who made the resources of the American Medical Association's library available to me, and to Phil Gunby, senior editor of the Journal of the American Medical Association, who kept me posted on current medical issues.

Gary J. Albert served ably as program assistant. His services in library research, data preparation, word processing, layout and proofreading were invaluable. Cherie Minor assisted with the typing of the manuscript drafts and George Kruto did the indexing.

The singular efforts of each of these individuals contributed to the whole. Any credit due is theirs to share. Any blame is mine. I thank them all, but as usual, my primary debt is to my family.

CHAPTER I

INTRODUCTION

Professionalism in medicine depends on our ability to provide quality care to the least of us. Alvin J. Thompson, MD[1]

Prison and jail inmates are overwhelmingly poor, are disproportionately minorities and have the added stigma of having been charged with transgressing society's laws. They do not vote, are essentially without power and there are few special interest groups concerned with their welfare. Why should anyone care whether the health services provided to these individuals are adequate? Perhaps because, as Doctor Thompson suggests, the care and treatment provided to the incarcerated is a reflection of the degree of professionalism attained by the field of correctional medicine and a hallmark of a civilized society.

Correctional health care as a separate field of endeavor is a relatively new phenomenon. It was not until the early 1970s that anyone began to focus on the type of health care and level of services provided to those who were incarcerated. In the 1970s, the primary problem was that few prisons (or jails for that matter) had a system of care in place. In the years that followed, two parallel forces -- namely, the courts and the health professional associations -- were at work defining what that system of care should be.

Two decades later, most state departments of correction have some semblance of a system of health care in place: some because they were mandated to do so by federal courts, others because they chose to follow the recommendations of the health professional associations. Nonetheless, a number of problems remain unsolved. The legal guidelines established by the courts and the standards developed by the health professional associations (most notably, the American Medical Association and the American Public Health Association and later, the National Commission on Correctional Health Care) offered a framework for improving correctional health care. For the most part, though, they did not provide much guidance as to how these improvements were to be accomplished. There was no reference book that individuals could turn to that discussed issues of implementation in any detail. It is intended that this book will help to fill that void.

The major purposes of this book can be summarized as follows:

1. To trace the historical, legal and ethical issues that characterize the field of correctional health care.

2. To develop a model of health care in prisons that addresses issues, problems, organizational structures, and programs, and provides guidelines for correctional and medical administrators and health practitioners.

3. To examine in detail the kinds of health programs that should be in place and their implementation in a correctional setting.

4. To suggest guidelines that contain the mechanisms for program implementation including national standards, policies, procedures, planning methods, budget development and staffing patterns necessary for a successful health program.

5. To provide a structure for the administration, monitoring and evaluation of ongoing programs.

6. To review issues and explore future needs in correctional health care.

This book focuses on health care in prisons. It is intended to serve as a reference for correctional and medical administrators as well as health practitioners working in the prison environment. While much of the historical, legal and ethical discussions as well as some of the planning and programmatic elements will apply to jails as well, some will not. For example, a model delivery system designed to meet the needs of a relatively stable, longer term population such as that in most prisons is likely to be very different from one designed to address the health needs of a more transient, short-term

population typical of most jails. In addition to practitioners, it is anticipated that others with interest in correctional health care such as lawyers, professors and students will find this book of value as well.

In compiling the material for each chapter, a variety of approaches was used including literature searches, on-site visits to selected prison systems and telephone inquiries. In all sections, the discussions reflect an awareness of court decisions and the requirements of national standards. The most important resource, though, proved to be the expertise of the members of the Editorial Advisory Board created for this project and that of the National Commission on Correctional Health Care's (NCCHC) staff. The combined knowledge and experience of these groups regarding how prison health systems should be organized and managed formed the basis for many of the chapters that follow. The content of the chapters is summarized below.

Chapter II provides a historical overview of the status of health care in correctional institutions and the need for reform. Barriers to improving the care are described along with early reform efforts including those of the courts and the professional associations. The chapter ends with a description of current programs aimed at improving the field of correctional health care.

Legal issues surrounding the provision of care in prisons are described in Chapter III and the origin of inmates' constitutional right to health care is discussed. The "deliberate indifference" standard articulated by the Supreme Court in 1976 in the landmark case of *Estelle v. Gamble* is presented along with relevant cases that have further defined the limits and extent of that legal standard. The chapter states briefly the legal requirements for providing basic medical, mental health and dental services, and touches on specific issues such as forced psychotropic medications, confidentiality and AIDS.

Chapter IV introduces a number of the ethical principles that are basic to health care providers including confidentiality and informed consent, and discusses them in the context of the correctional setting. Other issues are addressed such as the participation of inmates in biomedical research and the use of advance directives for the terminally ill. This chapter also offers guidance for ethical behavior when correctional health professionals are asked to participate in custody functions such as body cavity searches, collecting forensic information or witnessing use of force. Other ethical dilemmas posed by the use of restraints, disciplinary segregation, hunger strikes and executions are discussed as well. The chapter concludes with an examination of the circumstances under which it is appropriate for correctional health professionals to share limited information about their patients with custody staff.

The focus of Chapter V is on the organizational structure of prison health services. The results of an NCCHC survey are presented that demonstrate the variability of health services' organizational structure among the state departments of correction (DOC). The components of a model organizational structure are discussed including the need for a designated statewide health services director with line authority over unit health staff, the placement of health services within the DOC and the rationale for including medical, dental and mental health services under a single organizational umbrella. Additionally, the issue of contracting out health services to a for-profit firm is addressed and guidance provided regarding the elements that should be included in such a contract. Roles are suggested for health staff functioning at the central office, regional office and unit level.

Chapter VI concentrates on some of the staffing concerns that require special consideration in a correctional setting. Deciding how many health staff of each type are needed to provide the desired level of care is probably an administrator's most difficult task. Developing staffing patterns for prisons is complicated further by certain custody rules and regulations that affect productivity. Suggestions are made regarding the development of rational staffing patterns that take into account a number of special factors. Recruitment and retention of correctional health staff also present a special challenge. The need to review the DOC's employment package is discussed and guidance provided regarding offering certain benefits such as employee health care and employee assistance programs. Other topics addressed include the process of selecting staff and the provision of orientation and ongoing training for health professionals.

Chapter VII reviews the components of a model health care delivery system. The basic elements of the medical, dental and mental health programs are discussed along with ancillary services such as pharmacy, laboratory, radiology and medical records.

Guidelines are provided for conducting intake screening, health assessments and sick call as well as monitoring individuals who are chronically ill. Some of the considerations that should be taken into account in arranging for emergency services, hospitalization and other community referrals are described as well. Throughout this chapter, the requirements of the various sets of national standards are referenced and compared.

Chapter VIII addresses the topic of inmates with special health needs including those with specific chronic illnesses or communicable diseases. The special concerns of caring for other groups such as inmates who are suicidal, developmentally disabled or physically handicapped are addressed as well as the unique health needs of women offenders and the geriatric population. The need to identify these groups and plan for them is emphasized. Special housing, treatment and staffing implications are reviewed and model programs operated by various prisons are presented.

The thrust of Chapter IX involves strategies to prevent disease, to control infection and to promote health and safety in prisons. Detailed guidelines are presented for establishing and operating an effective environmental health and safety program. The requirements of the various sets of national standards governing environmental health issues are reviewed. Additionally, information necessary for institutions to implement infection control and communicable disease programs is provided. This chapter also argues for the necessity of developing aggressive health education programs for inmates. The public health perspective reflected in this chapter suggests that preventive measures can yield long-term savings in the cost of care.

Chapter X describes some of the issues that administrators and architects should take into consideration in planning correctional health facilities. The steps involved in the planning process are reviewed including creating the planning committee, determining its composition, and defining its objectives and scope of authority. The need for accurate data about the population to be served is stressed so that appropriate decisions can be made regarding the level of care and services to be offered at the new or renovated facility. The process of summarizing the design needs and developing an architectural program statement is reviewed. Some basic equipment needs are outlined as well.

The focus of Chapter XI is on data management and documentation issues. Basic information is provided regarding what data to collect, how to collect them and how they can be used in planning and managing prison health care services. The need for administrative statistics, utilization data, budgetary information and epidemiological data is stressed. Other documentation issues such as the use of standardized forms, the organization and management of medical records, and the efficacy of computers are reviewed.

The topic discussed in Chapter XII is quality assurance. Various strategies to improve the quality of care and reduce liability are discussed. Guidelines are established for implementing a quality assurance program for the DOC that addresses the role of both central office and unit health staff. Additionally, the benefits of review by external groups are presented and the accreditation programs offered by the American Correctional Association, the Joint Commission on Accreditation of Healthcare Organizations and the National Commission on Correctional Health Care are compared.

Chapter XIII is devoted to cost considerations. It describes the financing options that are available to fund correctional health programs and offers some advice on developing a budget and what to do when funding is insufficient. The results of an NCCHC survey are presented that demonstrate the escalating cost of care in prison health systems. Strategies for controlling costs are discussed as well.

The book concludes with Chapter XIV, which reviews the state of prison health care and suggests the areas that need refinement and emphasis over the next decade. Emerging issues and future trends are presented.

The appendices contain a number of sample forms, worksheets and checklists that may be of interest.

In all, the fourteen chapters and the appendices are intended to cover the gamut of reference to prison health care -- its past, the complexities of its present and a look toward its future needs.

ENDNOTES

1. Dr. Thompson, past president of the Washington State Medical Association, made this statement in a 1979 film of the American Medical Association entitled *Out of Sight--Out of Mind.*

CHAPTER II

HISTORICAL OVERVIEW:

THE MOVEMENT TO IMPROVE CORRECTIONAL HEALTH CARE[1]

Now it is true that the prisoner's basic material needs are met -- in the sense that he does not go hungry, cold or wet. He receives adequate medical care and he has the opportunity for exercise (Gresham Sykes, 1958:68).

Those words were written over thirty years ago by one of this nation's foremost criminologists. In attempting to make a point about the lack of amenities for inmates in prison, Sykes assumed that the necessities of life were provided. Nevertheless, by the 1970's, various studies and court cases had begun to document institutional atrocities that forced us to question seriously whether the necessities of life actually were provided to those behind bars. With respect to health care, consider the following accounts of treatment of inmates in some of the nation's jails and prisons only two decades ago:

> *According to her account,[2] she was constantly horrified and often terrified by the inhumanity on the part of both the staff and the inmates. It began with the physical examination when the matron searched seven women for concealed narcotics, using a vaginal tool without sterilizing it between the examinations. When Mrs. X protested, the matron made her the last of the women to be examined. The doctor who examined her took away her prescription medicine for a heart condition and never returned it although he had promised to do so* (Menninger, 1969:41).

> *His constant threats of suicide and his constant animation called for medical intervention. Indeed, the medical department found a solution to his problems that was not particularly unique in the nineteenth century but somewhat disconcerting in the 20th century: they filled him with tranquilizers and shackled his legs and arms to the bars*[3] (Goldsmith, 1975:83).

> *A quadriplegic, who spent many months in the hospital at the M & D C [Medical and Diagnostic Center], suffered from bed sores which had developed into wounds because of lack of care and which eventually became infected with maggots. Days would pass without his bandages being changed until the stench pervaded the entire ward. The records show that in the month before his death, he was bathed and his dressings were changed only once (Newman v. Alabama).*

> *Prisoners are supposedly screened during the classification process for job assignments so that men with health conditions which would be aggravated by a particular job or which would be unsafe to others are assigned appropriately. There are indications that the job assignment process does not function as intended. For example, a man at Camp Hill with a known heart and stomach condition was assigned to a garbage detail; he reportedly died after lifting heavy garbage pails* (Health Law Project, 1972:35-36).

In all fairness, though, Sykes should not bear the brunt of criticism for a remark he made in passing a number of years ago. A host of other authorities (and in the more recent past) failed to consider the pressing problem of health care in corrections. As noted by the American Medical Association (AMA) in its proposal to the Law Enforcement Assistance Administration (LEAA) for funding a correctional health program:

> *As recently as 1965...when the National Crime Commission studied a national sample of short-term institutions, it did not isolate health services as a topic of special concern. The Joint Commission on Correctional Manpower and Training established by Congress a short time later similarly failed to obtain systematic information on health*

services in jails and related institutions (December 1974:3).

Other authorities -- namely, the courts -- when confronted with instances of negligent or inadequate health care in correctional institutions chose to ignore it. Relying on the "hands-off" doctrine[4] established decades earlier,[5] the courts -- in most instances until the 1970's -- abstained from reviewing the actions of prison officials.

The medical profession itself, and in particular, organized medicine, expressed little interest in the plight of prisoners' health care until about 1970.[6]

The sections that follow explore some issues surrounding health care in prisons in greater depth. Section A examines the status of health care in prisons prior to efforts to improve it and identifies deficiencies in the then current systems of health care delivery. Section B reviews the barriers to improving the inmates' lot that previously existed. Section C outlines some of the justifications for upgrading health care in prisons and Section D discusses early attempts to improve prison health care.

Insofar as possible, this chapter focuses on health care in prisons as opposed to other types of correctional institutions. A prison is usually defined as an individual facility operated by a unit of state (or federal) government for the confinement of adults convicted of a felony whose sentence exceeds one year. In general, it excludes all short-term adult institutions, juvenile detention or shelter care facilities, half-way houses and overnight police lock-ups. The reader should note, however, that a number of authorities cited herein do not make this distinction and use the terms "prison" and "jail" interchangeably.[7] Additionally, many of the early studies and programs focused on jails rather than prisons and may be cited to make a point (see endnote 9).

A. The Status of Health Care in Prisons and Jails

No other system surpasses the jails for having the absolute worst health care system in the United States (Shervington, March 1974).

This quote reflects the growing belief that the status of health care in corrections was poor and that -- whether as a result of incarceration or not -- the health status of inmates also was poor. Until about 1970, there were few studies to support this belief. Indeed, as noted in the previous section, the issue itself was not generally a topic of concern.

After that time, however, a number of organizations began to study health care in corrections, albeit not in any systematic fashion. Many of the early available reports were theoretically rather than empirically based. They relied on anecdotes rather then experimental data to support their assertions. Even those few studies that tried to field-test some general notions about the lack of health care in corrections were usually methodologically flawed. Nevertheless, these studies represent the best information available on the issue at that time and thus, should not be dismissed out-of-hand.

In general, the common assumptions running through these studies included one or all of the following assertions:

1. Inmates were in poorer health than others of their age groups at the time they entered institutions;

2. There were a number of institutions in the United States that lacked any health care facilities;

3. Even in those institutions where health care facilities were available, the services offered and the care given may have been inadequate; and

4. The living conditions in jails and prisons themselves caused health problems.

In the sections that follow, each of these assertions is examined along with supportive evidence available from a review of the early literature.

1. Inmates Entered Institutions in Poor Health

Most of the evidence with respect to this assumption was indirect. In the early 1970's, there were no published studies that attempted to document the general health status of inmates at the time of their admission to jails or prisons and to compare their status with that of individuals in the community of similar age, sex and ethnicity. Instead, the statement was assumed to be true on the basis of

the interrelationships between poverty, crime and poor health.[8]

There was some evidence of the poor health status of inmates at the federal level. For example, one article decrying the inadequacy of health care in correctional institutions in general contained the following statement:

> *At the outset, the prison population is not healthy...the "typical" inmate enters prison with a 95% chance that he needs medical care and a 66% chance that the care he receives will be his first contact with professional medical attention. Furthermore, he has a 50% likelihood of drug abuse; a 5% chance of severe psychiatric disturbance and a 15% possibility of having serious emotional problems* ("Medicine behind bars," 1971:26).

The basis of these estimates went unreported, but the statistics were startling. Even more startling was the fact that the author was referring to the federal prison system. If Menninger and others were to be believed,[9] the situation at the local level must have been even more dismal.

While empirical studies detailing the overall health status of inmates at the time of admission were lacking, a few other reports were available that described particular health problems in prison and jails. These typically focused on problems of alcoholism,[10] drug abuse[11] and mental illness.[12] Although none of these reports dealt with alcoholism, drug abuse or mental illness specifically as medical issues, they did help to identify areas of medical need. Regardless of the exact numbers, the following seemed clear:

- A number of inmates were alcoholic, and thus, might exhibit both acute and chronic medical problems at the time of their admission including seizures, delirium tremens, malnutrition and chronic liver ailments.

- Some inmates in correctional institutions were substance abusers and, as such, were prone to diseases such as hepatitis in addition to other conditions that might accompany drug abuse.

- Some people who were mentally ill or retarded ended up in prisons and jails. Others became emotionally ill after incarceration -- as the number of suicides and suicide attempts as well as physical and sexual assaults attested.

- A host of other categories of offenders also ended up in correctional facilities, bringing their special medical problems with them. For example, prostitutes and homosexuals were more likely to have a higher incidence of venereal disease.

Seemingly, a number of inmates were entering institutions in poor health. It also was becoming clear that most jails and prisons lacked the facilities necessary to handle inmates' health care needs.

2. Many Institutions Lacked Health Care Facilities

A review of the literature suggests that the first national survey even to broach the question of the availability of health facilities in corrections did not occur until 1970.[13] Then, it was determined that only about half of the responding jails had any medical facilities at all.[14] True, the LEAA survey included only one item related to the availability of medical facilities and the nature of these facilities was unknown. Still, it was a beginning.

About the same time, the AMA began to show an interest in the status of health care in jails. In view of the dearth of data on the subject, the AMA decided to complete its own survey to determine the scope of the problem it was confronting. Meetings with correctional officials as well as a small exploratory study[15] had convinced the AMA that a problem existed and that organized medicine could play a part in its solution; but first, more information was needed.

A four-page questionnaire was mailed to 2,930 sheriffs administering local jails who were listed with the National Sheriffs' Association. Of the forms returned, there were 1,159 usable responses -- about 40 percent of the total number of questionnaires mailed.[16] From the responding jails, a dismal picture of the availability of health care facilities began to emerge:

- In almost two-thirds of the jails (65.5 percent), the <u>only</u> "medical facility" available within the jail itself was first

aid. An additional 16.7 percent reported that not even first aid was available.[17]

- Twenty-eight percent of the jails said that no physician was available to the institution on a regularly scheduled basis and 11.4 percent said that physicians were not available even on an "on-call" basis.[18]

- Only 37.8 percent of the jails indicated that a dentist was available to their institution and only seven jails (less than one percent) said a dentist made daily visits[19].

The jails' availability of facilities for handling the medical problems of special categories of offenders was no better. Fewer than 20 percent of the responding jails had any special facilities for handling alcoholics, only 10 percent had facilities for drug addicts and only 14 percent had facilities for the mentally ill.[20]

Admittedly, the AMA survey suffered from some methodological difficulties and the response rate was not an optimal one; however, another survey taken that same year, but not reported until 1974, tended to support the AMA's findings with respect to the availability of medical facilities and staff in jails.[21]

Seemingly, medical manpower and facilities did not exist on a formal basis in the majority of the nation's jails and, even where they did exist, there was no assurance that they were adequate. But what about prisons?

Unfortunately, there were no comparable national surveys that attempted to identify the level and extent of health services in state correctional systems. Indeed, such a survey still has not been conducted. The evidence that does exist from those few states where studies of prison health care delivery were done (e.g., Kansas, Kentucky, Maryland, Massachusetts, Michigan, Pennsylvania, Washington),[22] or from court cases of that era (e.g., *Newman v. Alabama*, *Holt v. Sarver*) indicates that, contrary to popular opinion, health systems in prisons were not better than those in jails.

It can be argued that in some ways prison systems may have been worse. For example, the lack of ongoing health services and the lack of facilities in jails often meant that when inmates "really needed" care, they were sent to the local hospital emergency department to receive it. While this may not have been the most efficient or least costly alternative, at least the care received met community standards. In contrast, most prisons tended to have some facilities for health care on-site and hence, may have been more reluctant to send an inmate to the "free world" for care. The health staff in prisons, though, often consisted of physicians with institutional licenses or unlicensed foreign medical graduates, supplemented by unlicensed medical corpsmen and untrained inmate "nurses."[23] As noted below, these factors and others scarcely meant that health care in prisons was adequate.

3. Health Care in Corrections was Inadequate

The third common assertion running through the literature was that even where medical manpower and facilities did exist in correctional institutions, the care given was often inadequate. Most of the studies reflecting this view were done on state prison systems, so here, the evidence is direct.

One of the first studies to focus on the adequacy of health care in prisons (and the only known national study to date) was undertaken by the National Society of Penal Information in 1929.[24] After describing the generally inadequate conditions of the health care delivery systems in the prisons studied, Rector outlined some minimum standards for medical care in institutions. These included recommendations for all inmates to receive physical examinations by a "competent physician" both at the time of admission and at the time of discharge from the institution. Rector also indicated that daily sick call should be held by a physician and that complete dental care and complete optometric care should be available.[25]

Later studies indicated that these standards were still largely unmet. For example, the 1972 AMA survey noted that fewer than seven percent of the jails examined all inmates as a matter of course. In most instances, physical examinations were given, if at all, only when the inmates complained.[26] Similar findings were reported in a Massachusetts study of state prisons[27] and in those of the Kansas[28] and Kentucky systems[29] as well. Daily sick call was not a universal norm,[30] and even when held, it was not necessarily of good quality.[31]

Mental health services were lacking also. The absence of screening mechanisms[32] and testing services[33] coupled with deficiencies in staffing and facilities[34] meant that inmates' mental health needs frequently were not addressed.

Dental care, when available, often was limited to emergency extractions, with little thought given to restorative or preventive care.[35] This situation existed in spite of the fact that dental services are seriously needed by the vast majority of inmates.[36] Optometric care was virtually non-existent.[37]

4. Prison Conditions Themselves Caused Health Problems

The fourth assertion often found in the literature was that the living conditions in prisons and jails were themselves harmful to inmates' health. Of the numerous deficiencies listed, those concerning crowding, inadequate diet, poor sanitation, and lack of recreation and exercise facilities were the most frequent and the most serious. Many reports suggested that if inmates were not sick when they entered institutions, they would become so once they got there.

The general living conditions that reportedly existed in jails and prisons in the early 1970s were, for the most part, atrocious. To begin with, a sizable number were old and outmoded and many more were in disrepair.[38] Adequate lighting, heating and ventilation were often unavailable and air conditioning was a luxury provided to few. More importantly, sanitary conditions frequently were lacking.[39]

The literature is replete with examples of unsanitary conditions and practices in correctional facilities. The Pennsylvania study noted earlier reported instances of cockroaches in the dining room, rat droppings in the kitchen, medical reports documenting mice bites, and infestations of lice and vermin.[40] Similar conditions were found in some of the institutions in the Michigan study[41] as well as documented in a number of court cases of that era.[42]

Further, the Pennsylvania study indicated that "no institution had an established routine for physical inspection of the premises to monitor cleanliness" (Health Law Project, 1972:23). These same findings were borne out by the 1972 AMA survey, which found that although most of the respondents stated that sanitary inspections were made, the usual person conducting those inspections was the sheriff.[43] At the prison level, Walker and Gordon (1977) noted that environmental inspections, where conducted, were usually the responsibility of correctional officers who were not trained as environmental health specialists.

Finally, the National Advisory Commission in its discussion of major institutions indicated that:

> *Many institutions are poorly cooled, heated, and ventilated. Lighted levels may be below acceptable limits. Bathroom facilities often are insanitary, too few, and too public. Privacy and personal space hardly ever are provided because of overriding preoccupation with security. Without privacy and personal space, inmates become tense and many begin to react with hostility. As tension and hostility grow, security requirements increase; and a negative cycle is put into play.* (1973:355).

Deficiencies also existed in the management of food services as well as in the nutritional content of the meals. In the Michigan study, it was noted that "beverage milk handling in most locations observed was at best primitive, and at worst risks contamination and transmission of infection, particularly of the enteric diseases." Additionally, there were "...faulty and insanitary equipment and utensils...unclean storage refrigerators, improperly cleaned and maintained equipment and insufficient hand washing lavoratory facilities..." (1975:327). The Kentucky survey of penal institutions showed similar deficiencies. Further, sufficient nutritional content in the daily diet may have been lacking;[44] a hot meal may have been served only once a day;[45] and what was served may have been so unattractive as to make it virtually inedible.[46]

Beyond the inadequacies of sanitary conditions and diet, crowding once again was becoming a serious problem with which to contend. For a period of time during the late sixties and early seventies -- when community treatment of offenders and diversion were most in vogue -- prison populations began to decline. In 1970, the National Jail Census found that only five percent of the jails in its survey reported overcrowding.[47] In contrast, however -- whether as a result of a backlash against community treatment programs or simply an increase in the number of young people in the general population -- a 1976 survey found that the number of inmates in state and federal institutions was at an all-time high and that crowding in many areas had reached crisis proportions.[48] A 1978 survey of state and federal prisons reported that "across the nation, 46 percent of federal inmates and 44 percent of state inmates

lived in high density, multiple occupancy units" (Mullen, 1980:61-63).[49]

The effects of crowding on inmates' physical and psychological health status have been debated by researchers for years. A host of psychological studies have been undertaken that yielded contradictory results.[50] While some have claimed that suicide,[51] violence,[52] or stress[53] in prisons increases in crowded conditions, others have pointed to the methodological flaws in such research.[54] The data on the physiological effects of crowding are much more compelling and less speculative, though. A number of researchers have demonstrated that the risk of tuberculosis transmission[55] as well as other airborne bacteria and viruses[56] increases in crowded conditions.

To add to the health hazards of unsanitary environments, inadequate diets, lack of personal hygiene and crowding, respite -- however temporary -- from these dismal facts of life was rare. The lack of outside exercise yards[57] or indoor gymnasia, the dearth of meaningful work or sufficient educational and vocational programs,[58] and a lack of other recreational activities meant that many inmates served their terms in forced idleness.

These factors, taken together, clearly constituted a public health hazard that was staggering.

B. Barriers to Improvement

If all of these conditions with respect to health care existed in correctional institutions, why was so little done about it? A portion of the blame surely rests with that universal claim of "inadequate resources." True, corrections often has been referred to as the "stepchild" for its failure to obtain sufficient resources from state legislatures. It also may be true that in many communities, the public has shown reluctance to provide better conditions for those who have transgressed its laws or offended its sense of morality; however, as public officials know all too well, public opinion can be changed -- or even ignored when the purpose suits them. Thus, if it were only a question of inadequate resources, the task of improving health care in prisons would have been relatively easy. Pressures could have been brought to bear to appropriate the necessary funds.

The real barriers to improvement, however, were more difficult to overcome. They involved attitudes as well as actions and were, therefore, all the more entrenched. Included in this latter group were the positions taken by the courts, the attitudes of prison officials and the realities of the inmate social system as well as the problems and disinterest of the medical profession. Each of these barriers is examined in turn.

1. The Courts and the "Hands-Off" Doctrine

A century ago, individuals incarcerated in penal institutions had virtually no rights. Zalman states that prisoners were considered to be "slaves of the state and entitled only to the rights granted them by the basic humanity and whims of their jailors" (1972:185). In reality, that statement would be more accurate if the word "rights" were changed to "privileges." Until recently, the courts clung to a distinction between rights and privileges as a justification for their failure to review the actions of prison officials in their treatment of inmates.[59]

Judicial attitudes "prevented the expansion of the few 'privileges' afforded prisoners into meaningful 'rights'" (Hirschkop, 1972:452). With the exception of the Eighth Amendment's general prohibition against cruel and unusual punishment, there is nothing in the United States Constitution that applies directly to the protection of inmates. Thus, in the absence of specific constitutional provisions to the contrary, the courts chose to interpret the realm of prison administration as beyond their jurisdiction to review.

In addition to relying upon the concept of separation of powers, the courts also reasoned that they lacked the necessary expertise in penology to determine whether actions of prison officials were justifiable and stated a further reluctance to interfere based on the notion that such intervention might subvert prison discipline.[60] The inevitable result of this "hands-off" policy by the courts was to grant prison administrators broad discretionary powers in the way they cared for and treated their charges.

State courts often hid behind the hands-off doctrine in dismissing petitions for writs of *habeas corpus* or granted relief only where the petitioner could show that medical treatment or the lack of it amounted to cruel and unusual punishment of such a magnitude as to "shock the conscience of the court".[61] That extreme deprivation had to be present before the courts would grant relief was demonstrated in a 1963 Utah case, *Hughes v. Turner*. In this instance, the prisoner's complaint that he was being denied "sufficient food for his sustenance and comfort" was dismissed by the court, which ruled that hunger pains were subjective.[62]

Relief was further limited by the fact that federal appellate review of state prison administrators' actions and state court decisions was virtually unavailable until the 1960s. Like the state courts, the federal courts took refuge in the hands-off doctrine, but added the concept of federalism as further justification for their abstentions from review. Under this latter policy, powers not specifically delegated to the federal government were said to rest with the states and the constitutional protections of the Bill of Rights were held to extend only to federal issues.

With the passage of time, one by one, the guarantees of the Bill of Rights were said to be incorporated in the Fourteenth Amendment and made applicable to the states. Thus, the Eighth Amendment was judged to be so incorporated in a 1962 case, *Robinson v. California*. The result of this extension was to open to federal judicial review state cases charging a denial of Eighth Amendment constitutional protections. Further power for the federal courts to intervene in state matters was obtained by "the Supreme Court's explicit recognition in *Cooper v. Pate* that state prisoners could seek to invoke the protections of the Civil Rights Act (§1983)" (Alexander, 1972:17) -- an act passed by Congress in 1871.

The immediate effect of these decisions, however, was not to broaden the remedies available to prisoners alleging cruel and unusual punishment. Rather, they initially served to entrench the federal courts further in their use of the hands-off doctrine. In the area of medical treatment, the doctrine itself was refined and "three theories emerged to limit the concept that the denial of medical care amounted to cruel and unusual punishment" (South Carolina Department of Corrections, 1972:147).

The first theory generally held that an action for deprivation of civil rights under §1983 was not a substitute for available state remedies for damages. The second invoked the notion that deprivation of medical care must be so barbaric or extreme as to "shock the conscience" of the court before it would constitute cruel and unusual punishment. Under this test, all manner of cases alleging deprivation of medical care were denied relief for failing to reach constitutional magnitude (see e.g., *Snow v. Gladden*; *Krist v. Smith; Haggerty v. Wainwright*). In the third instance, the courts distinguished between the availability of medical treatment and the adequacy of treatment given. Where the issue was adequacy and not deprivation of medical care, the courts deferred to the opinion of prison physicians and officials that reasonable care was being provided. As long as some treatment was given, the courts were reluctant to determine that it was not sufficient.[63]

The effect of these actions, taken together, was virtually to bar prisoners from obtaining redress for anything but the most extreme deprivation of medical care. The courts relied on the willingness of officials "to do the right thing" without judicial intervention in prison administration; however, as indicated in previous sections of this chapter, that trust was not always well-founded.

2. Prison Officials and the Inmate Social System

The failure of correctional officials to provide adequate health care for inmates becomes more understandable, if we examine the goals of the prison system. Although jails existed in the eighteenth century,[64] the use of prisons as a form of punishment in America began only in about 1820.[65] The creation of the prison was initially undertaken as a reform movement: "...discipline 'directed at the mind' replaced a cluster of punishments 'directed at the body' -- whipping, branding, the stocks, and public hanging" (Ignatieff, 1978:xiii). There was a strong religious component involved in "the invention of the penitentiary" (Rothman, 1971:79). In fact, the term "penitentiary" is derived from the Puritan notion of doing penance for one's sins. According to Rothman (1971:105), "the doctrines of separation, obedience and labor became the trinity around which officials organized the penitentiary." It was believed that such a regimented life would transform the offender and that "the penitentiary would promote a new respect for order and authority" (Rothman, 1971:107).

While today's correctional administrators have all but abandoned the "rehabilitative ideal"[66] as a purpose of prisons, the politics of prison punishment[67] and prisons' quasi-military management style remain much the same. Issues of "security" and "order" still take precedence over all other considerations. Prisons exist almost solely for the purpose of custody. To the extent that health services are not seen as contributing toward that goal, they are likely to be given a low priority. In fact, according to one researcher, "to many correctional officers, medical department activities, which often require seemingly excessive movement of inmates, drugs and vulnerable people (particularly nurses) on cellblocks, not only do not contribute to

but are disruptive of basic prison goals" (Goldsmith, 1975:24).

Further, while the existence of some of the atrocious living conditions and inadequate health services described elsewhere in this chapter may have been owing to the deliberate cruelty of some officials, the more prevalent attitudes simply may have been ones of indifference to the inmates' plight, or beliefs that the deprivation was justified or that the inmates were "faking." By virtue of the fact that they are in prison, correctional staff may feel that inmates are undeserving of basic human considerations. As Goffman points out, staff notions of moral superiority are one of the characteristics of total institutions:

> *In total institutions there is a basic split between a large managed group, conveniently called inmates, and a small supervisory staff.... Each grouping tends to conceive of the other in terms of narrow, hostile stereotypes, staff often seeing inmates as bitter, secretive and untrustworthy, while inmates often see staff as condescending, highhanded and mean. Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy and guilty* (1961:7).

In jails and prisons, the reciprocal roles of inmates and staff are compounded further by the continuous struggles for power.[68] While correctional officers normally have the upper hand, inmates may spend inordinate amounts of time thinking up ways to subvert prison discipline and manipulate officials to their advantage.[69]

In regard to medical matters, correctional officers are well aware of the additional benefits that may accrue to inmates who are ostensibly seeking relief from illness or pain. A trip to the prison's infirmary or to a hospital on the outside offers the inmate the further possibilities of: escaping the usual boredom of the day's routine, getting out of an undesirable or unwanted work situation, "scoring" such items as drugs and supplies that later may be used as currency, meeting with other inmates or family members who may be at the infirmary or hospital by pre-arrangement, and finally -- the most disturbing of all possibilities to correctional officials -- a chance to escape.[70]

Given their usual distrust of inmates and the knowledge that inmates can fake illness to their own advantage, some correctional officers become cynical and refuse to believe that any except the most obviously ill need care. Other staff are resentful that convicted criminals are given what they perceive as a level of care and a degree of access denied to them and their families. Beyond that, correctional officers have been known to make the system of health care work to their advantage in one of several ways. Since in the past access to medical care usually was controlled by the security staff, they could either withhold it as a disciplinary measure or grant it as a special privilege. In either case, it was likely that a number of inmates actually needing medical care were not receiving it. Similarly, officers and correctional administrators have been known to exert considerable pressure upon clinicians (sometimes in a very subtle manner) to treat a patient more conservatively than was properly indicated -- particularly when off-site, inconvenient or expensive treatment is involved. It also happens that a shortage of escort or transportation officers (or vehicles) becomes a convenient excuse for denying (or at least delaying) care.

3. The Medical Profession and "Hands-On" Care

It has been pointed out at various points in this chapter that prisons lacked sufficient coverage by medically trained personnel and that sometimes those who served inmates were uncaring, or worse, incompetent. This very fact resulted in the attachment of a disparaging stigma to the term "prison doctor," creating a vicious cycle by making it even more difficult to recruit qualified and dedicated health professionals. There were other reasons as well for the shortage of competent physicians and allied health personnel in correctional facilities. In some instances, there may have been a shortage of physicians and medical resources in the community at large. Prisons tend to be located in rural areas and are, therefore, out of the "medical mainstream." In other cases, the prisons failed to allocate sufficient monies to attract and retain qualified health professionals. In still others, the correctional facility's policy of refusing to hire women for jobs "behind the walls" meant that inmates were medically underserved.[71] Additionally, the working conditions at the prison and the ingrained attitudes of health professionals themselves often acted as even more effective barriers to improving existing conditions.

To begin with, the prison itself was not likely to be a comfortable place to work. The general

atmosphere may have been unattractive and oppressive, the conditions unsanitary and the working space for health services inadequate. Supplies and equipment frequently were insufficient and outmoded and the provision for back-up facilities within the prison and support services in the community often were non-existent.

Further, the prison offered the health professional -- especially the physician -- little in the way of money, status or prestige. In addition, the patients that the physician served were likely to be professionally uninteresting. S/he probably encountered few cases that represented an intellectual challenge. Instead, the physician was confronted with a series of common ailments -- both real and claimed -- for which treatment is fairly routine.[72] Much of the correctional physician's workload consists of holding sick call and performing standardized physical examinations. Actual emergency situations are rare in most institutions and are as likely to occur when the physician is away from the prison as not.[73]

To compound these issues were the attitudes and values of the physicians themselves. If a gap exists between the life styles and the belief systems of corrections officials and inmates, the social distance between physicians and inmates is even greater. Moreover, the correctional setting is not conducive to developing a relationship of mutual trust. Inmates may view health professionals as allies of the corrections staff and fear that the usual doctor/patient privilege may be abrogated in favor of security concerns. By the same token, a physician who has been "conned" once too often may come to view almost all inmate medical complaints as attempts at manipulation.[74] This conflict, from the physician's perspective, has been described as follows:

> *The physician in our society, goal oriented, hard working, motivated by intellectual, economic and ego needs, has little empathetic relationship with the prisoner who is a patient. In addition, it is not beyond reason to suspect that the physician believes the prisoner is an exploiter, a malingerer, and even a source of veiled and violent threat. With so much to be done in this world, is the valued time of the physician to be spent in this area?* ("A proposal for the improved care of prisoners in the state of Maryland...," undated:8 as quoted in AMA, 1974:19).

The physician/inmate relationship is further complicated by the attitude and belief structures of the correctional staff. A physician who wants to practice good medicine may not be allowed to do so. On one end, the warden may control the direction of the medical program in addition to its purse strings. On the other end, line personnel often control inmates' access to medical services. The physician and other health personnel are caught somewhere in the middle. They must walk a tightrope -- trying to balance the real medical needs of inmates with the security concerns and priorities of the line and supervisory correctional staff. If the health care personnel become overly identified as "inmates' advocates," they run the risk of having their program subverted by correctional staff. If, however, they lean too far toward the security side, their relationship with their patients is jeopardized and the inmates' medical needs may not be served adequately.

Given all these factors, it is easier to understand why working in the nation's prisons may have been less attractive to competent health professionals than opportunities in other settings in the community. Regardless of the reasons, though, the fact remained that prisons and other correctional facilities were medically underserved.

C. Justifications for Improving Correctional Health Care

No matter how formidable the barriers seemed, by the 1970s, it was becoming clear that society had an obligation to make improvements in correctional health care. There was a growing awareness of the extent of deficiencies. Justifications for assuming this monumental task were manifold, including ethical considerations, security reasons, humanitarian and health concerns, and legal issues. In addition, and perhaps for all of these reasons, improved correctional health care was being recognized by many simply as good public policy.

1. Ethical Considerations

Some of the most compelling reasons for improving health care in correctional facilities were based on moral principles. There was a growing belief in our communities in general that good health care should be a right extended to everyone and not a privilege available only to those who could afford it.[75] With respect to prisoners, there was an increasing recognition by the courts that a government is not entitled to withhold the basic

necessities of life from its charges and that access to health care was one of the necessities.

One of the most encouraging signs indicating that prospects for change were good was the support received from correctional representatives themselves on the subject of inmates' rights to health care. The National Advisory Commission on Criminal Justice Standards and Goals phrased it this way:

> *One of the most fundamental responsibilities of a correctional agency is to care for offenders committed to it. Adequate medical care is basic, food and shelter are basic. Withholding medical treatment is not unlike the infliction of physical abuse. Offenders do not give up their rights to bodily integrity whether from human or natural forces because they were convicted of a crime* (1973:36).

From the U.S. Bureau of Prisons' manual on jails came this strongly worded statement:

> *No jail is too small to provide adequate medical care. Whether the jail holds one inmate or a thousand, the administrator has a responsibility to protect the health of his prisoners and to safeguard the health of the community. He cannot meet this responsibility if he does not provide medical care for prisoners. Certainly no jail administrator has the right to impose a death sentence, and failure to provide for the medical needs of those in custody is equivalent to pronouncing a death sentence* (Pappas, 1972:140).

Even more heartening, however, was a statement from the National Sheriffs' Association (NSA) which read, in part, as follows:

> *Insufficient resources and inadequately trained custodial personnel are repeatedly cited as reasons for the lack of adequate medical and dental care, as well as for the absence of recreational programs and facilities.*
>
> *But while all these conditions and problems may prevail in a given institution, they do not alter the responsibility of the jail administrator to fulfill the right of each person in custody to a healthful and safe environment. The duty of the jailer is not simply to keep secure those entrusted to his custody, he must care for them as well* (1974a:13, emphasis added).

And finally, the American Correctional Association had this to say:

> *The objectives of a health and medical services program for prisoners must include the promotion of health, the prevention of disease and disability, the cure or mitigation of disease, and the rehabilitation of the patient.*
>
> *Good medical care cannot be promoted when services are rendered on the basis of a double standard, as for instance, one for "paying patients" and one for "public charges." To achieve the goals set down above, medical care programs for prisoners must be equivalent in quality to the care which is available in the community. Acceptance of a lesser standard will make impossible the achievement of these goals* (1966:436).

2. Security Reasons

Another set of arguments for improving correctional health care was based on the belief that it also would improve a prison's security. If "custody" is the primary purpose of prisons, then order and security must be maintained if that objective is to be achieved. Since anything which threatens that order is against the prison's primary interest, it seems safe to assume that a warden would be interested in reducing that threat. In this vein, it was possible to justify improving inmates' health services as a way of reducing prison violence.

Undoubtedly, there have been few riots in history that have not been said to have been precipitated -- at least in part -- by the appalling conditions and inhumane treatment that existed in those institutions. In virtually every account of a riot where inmate demands are made, the list of requested reforms includes better diet and general living conditions as well as improvements in the access to and adequacy of the health care provided.[76] According to this viewpoint, riots and other instances of prison violence are a direct result of intolerable conditions that reach a crisis proportion and then the institution explodes.

There are those who do not agree with this "prison-as-a-powder-keg" theory of the cause of riots,

among them penologist Lloyd McCorkle. McCorkle believed that riots occur because the people inside are unhappy. He did not think that riots were necessarily related to inmate complaints regarding poor conditions. In fact, he believed that the lists of grievances often were drawn up after the fact in an effort to legitimize the riot in some way.[77]

If McCorkle is right, then the argument that improving prison conditions will reduce the threat of violence is a specious one. Following the Attica uprising in 1971, however, a number of correctional observers again reasserted this theory.[78] Hence, another justification for improving correctional health care was added to the growing arsenal for reform.

3. Humanitarian and Health Concerns

If ethical and security considerations were not sufficiently convincing, further justification was found in humanitarian and public health reasons. To begin with, the idea that society owed the inmate health services that were at least comparable to those available to the general public was gaining ground. In fact, there was a growing belief in some circles that society had an even higher duty to care for inmates, since they were not free to care for themselves.[79] Considering the fact that many inmates entered prisons and jails in poor health and that the institutions themselves often exacerbated their conditions, any position to the contrary became difficult to justify on humanitarian grounds.

Beyond that, it was becoming increasingly apparent that providing inmates with adequate health care was important not only for their welfare, but for that of the community as well. There was a growing recognition among health professionals that the costs and consequences to the public of not providing necessary care while inmates were confined would be compounded when they were eventually released. For example, few facilities provided routine communicable disease screening of inmates on admission. Given the high risk population of prisons and jails in terms of communicable diseases[80] and the relatively short-term nature of their incarceration patterns,[81] the potential public health consequences of not performing this routine screening were considerable. Not only were inmates at risk of contracting a disease while incarcerated, but also there was the very real danger of inmates transmitting disease to their families and friends upon their release.[82]

Further, that acute and chronic illnesses often were not treated in prisons and jails did not mean society did not bear the burden of paying for necessary treatment eventually. When inmates are released, a sizeable number find their way onto the rolls of a variety of government-sponsored programs such as welfare, Medicaid and departments of rehabilitation. Thus, communities were simply delaying their costs, not avoiding them. In fact, it can be argued that they were increasing their costs by not providing preventive and restorative care and, therefore, allowing conditions to deteriorate to a more serious -- and presumably, more expensive -- level.

Finally, the failure to provide adequate medical care for inmates can result in additional costs to the community by reducing the chances for inmates' successful reintegration. Inmates may become bitter and more anti-social as a function of the indignities they endure in a correctional setting. Since feelings of well-being and self-esteem are virtually prerequisites for constructive change, neglecting inmates' health needs only compounds their already difficult task of readjustment. The National Advisory Commission phrased it this way:

> *Medical care is of course a basic human necessity. It also contributes to the success of any correctional program. Physical disabilities or abnormalities may contribute to an individual's socially deviant behavior or restrict his employment. In these cases, medical or dental treatment is an integral part of the overall rehabilitation program* (NACCJSG, 1973:37).

4. Legal Issues

In the final analysis, however, it may be simply that correctional administrators no longer had much choice whether or not to provide adequate health care for their charges. During the early 1970's, the federal courts in particular began to overcome their previous reluctance to intervene in matters regarding the internal administration of correctional facilities. Emerging case law at all levels of government began to dictate that at least certain basic elements of adequate health care be provided.

The case that signaled the beginning of the reversal of the "hands-off" doctrine with respect to prisoners' rights to medical care was *Newman v. Alabama*. In this October 1972 decision, a United States district court found the whole state

correctional system of Alabama to be in violation of the Eighth and Fourteenth Amendment rights of the inmates it held by failing to provide them with adequate and sufficient medical care. In what has been described as "the first major federal civil rights action devoted entirely to prison medical care" (ABA, August 1974a:144), the court placed the state's correction agency under injunction and demanded immediate remedies for all existing deficiencies. Cost considerations were held not to be sufficient defense for failing to provide care. Subsequent review at the circuit court level upheld this landmark decision.

Following closely on the heels of *Newman* came a host of other cases that began to carve out specific rights related to inmates' general health and well-being. According to a General Accounting Office report (April 1976, Appendix I), courts at various levels ruled that certain inmates in certain places were entitled to:

- "the essential elements of personal hygiene (e.g., soap, towels, toothbrush, toothpaste and toilet paper)" (see e.g., Finney v. Arkansas Board of Corrections, *Holt v. Hutto*);
- adequate and sanitary living conditions (e.g., sufficient space, heat, lighting, and ventilation; clean laundry; essential furnishings.) (see e.g., *Gates v. Collier*);
- "adequate drinking water and diet, prepared by persons screened for communicable disease in kitchens meeting reasonable health standards" (see e.g., *Holt v. Hutto*);
- competent medical and dental care backed up by competent supportive facilities (see e.g., *Gates v. Collier*, *Finney v. Arkansas Board of Corrections*);
- drugs and special diets that are medically prescribed (see e.g., *Finney v. Arkansas Board of Corrections*, *Steward v. Henderson*);
- drug detoxification and/or treatment for drug dependence (see e.g., *Wayne County Jail Inmates v. Lucas*);
- professional treatment and evaluation of psychiatric problems in appropriate settings for detainees under civil commitment (see e.g., *O'Connor v. Donaldson*);
- utilize exercise and recreational areas (see e.g., *Rhem v. Malcolm*);
- have visitors, touch their visitors and make telephone calls to the outside world (see e.g., *Rhem v. Malcolm*).

At first glance, this appears to be an impressive list of inmates' rights. It should be noted, however, that this list was compiled from a number of cases in different parts of the country, not all were federal court decisions and not all applied equally to all categories of inmates (e.g., some applied only to detainees or to civil commitments). It should be noted further that while precedents may be established, court decrees are binding only on the specific litigants involved. Thus, in the absence of a Supreme Court decision or specific federal legislation making prisoners' rights to health care binding on all the states, there was no assurance that correctional administrators would follow the developing legal trend of safeguarding inmates' rights to medical care. Other solutions to improving correctional health care still were needed.

D. Early Solutions -- The Beginning of Reform

During the 1970's, interest in ensuring adequate health care for inmates was growing in areas outside the courts. Correctional and medical personnel at both the state and national level were indicating concern over the existing deficiencies in health care in correctional facilities and were attempting a series of solutions. These solutions usually took one of two forms: either the implementation of specific programs designed to improve health care in certain facilities or the development of standards for health care.

1. State, Local and National Programs

The early 1970's saw an increase in the number of programs at specific correctional facilities that were designed to improve some aspect of health care for inmates or to alleviate some particular medical condition. At the state correctional level, there were a few attempts to improve health care systems. For instance, Texas developed an innovative program "designed to introduce medical students to the problems and concerns of prison health care" (Texas

Department of Corrections, 1974); the Georgia Department of Corrections received a substantial grant from LEAA to revamp its health care system and reallocate its prison health care dollar in a more efficient fashion; and, as a result of the federal court's intervention in *Newman*, health care in Alabama's correctional system underwent some improvements. The literature also reflected a few programs designed to improve specific medical conditions of prisoners such as facial disfigurement[83] that met with varying degrees of success.[84]

At the local level, there were a couple of programs specifically designed to improve overall medical care in a given jail,[85] but most of the programs concentrated on a particular medical problem -- for instance, drug abuse[86] -- or were funded to alleviate general problems such as poor and/or unsanitary living conditions, inadequate security or safety measures, and insufficient attention to the comfort, rehabilitation and privacy needs of inmates.[87]

The fact that a few programs were being funded, though, did not mean that they were producing the desired changes. For example, the General Accounting Office surveyed twenty-two jails that had received federal funding to improve conditions and concluded that inadequacies still remained. The report pointed out that efforts to improve conditions were hampered by the fact that "there are no nationally acknowledged standards to be applied in determining whether physical conditions are adequate and whether sufficient services are available in local jails" (GAO, April 1976:i).

In 1975, however, the Law Enforcement Assistance Administration (LEAA) provided a grant to the American Medical Association (AMA) to upgrade correctional health care. The focus of the initial pilot effort was to develop model health care delivery systems in a number of jail sites; devise correctional health care standards that would serve as the basis for implementing a national accreditation program; and establish a clearinghouse to develop and disseminate information on correctional health care issues.

The LEAA-funded AMA program continued through 1981 and, by all accounts, achieved its program objectives.[88] It started by involving six state medical societies that worked with a total of 30 jails:

> *Six years later, 25 medical societies and more than 400 jails had been participants. In addition, the program had accomplished the following:*
>
> - *the development of model health care delivery systems for jails;*
> - *the establishment of three sets of health care standards (for jails, prisons, and juvenile facilities) covering medical, dental, mental health, and chemical dependency services;*
> - *the development of 20 different monographs on various correctional health care topics...as well as a "Practical Guide" for implementing standards and an accreditation brochure;*
> - *the completion of an award-winning documentary film on health care in jails entitled Out of Sight -- Out of Mind;*
> - *the compilation of an annotated bibliography on medicine and criminal justice;*
> - *the development of a training package for jailers on receiving screening and other aspects of correctional health care;*
> - *the dissemination of more than 210,000 copies of AMA correctional health care publications;*
> - *the holding of five successive conferences on correctional health care, which were well received by the participants;*
> - *the accreditation of the health care systems in 111 facilities; and*
> - *the expansion of the accreditation effort to jails in all 50 states.* (Anno, 1982:2924)

In 1977, LEAA awarded a grant to the Michigan Department of Corrections, Office of Health Care, to provide technical assistance to ten states to improve health services in their prison systems. Subcontracts with the School of Public Health of The University of Michigan and with the Colleges of Human and Osteopathic Medicine at Michigan State University provided staff, additional expertise and training

resources to assist in this effort. Aside from the benefits of training and assistance that may have accrued to the prison health personnel in the selected states, probably the most lasting effect of this program was the development of 19 separate manuals on various health topics such as diet, dental services, pharmaceuticals, education programs, quality assurance and policy development among others. The CHCP (Correctional Health Care Program) manuals were printed in 1980 and, while some of the material may require updating, much of it is still very useful for today's prison health personnel.[89] The AMA's draft *Standards for Health Services in Prisons* (1979) described below, were broadly circulated by the CHCP, where they were reviewed by hundreds of correctional health providers and administrators.[90]

2. National Standards

At the national level, early attempts to improve correctional health care generally consisted of "standard setting." Key professional correctional organizations affirmed prisoners' rights to adequate health care and outlined the essentials that should be included to safeguard these rights. Standards for medical care and healthful environments were established by both the National Advisory Commission on Criminal Justice Standards and Goals (1973) and the National Sheriffs' Association (1974a-e). In addition, the American Correctional Association (ACA) began the process of revising its *Manual of Correctional Standards* (1966), which included health care as one of its topics. In the 1966 edition, a total of only eight pages had been devoted to a discussion of health and medical services.

There were, however, difficulties with the standards that had been established so far. In the first place, they were almost always too general to provide much impetus for change.[91] Courts and correctional administrators seeking specific guidelines as to what constituted "adequate" provisions for health care were not likely to derive much satisfaction from the early standards. The interpretation of words such as "access," "available," "reasonable," "appropriate" and "acceptable" as well as the determination of specific elements and services to be included in, for example, "physical examinations" or "emergency treatment on a twenty-four hour basis," were left entirely to the discretion of the reader. Secondly, the standards lacked enforcement power. The national standards were simply suggested guidelines that prisons and jails were free to adopt or reject as they chose. Clearly, what still was needed was a set of standards that would provide more specificity and enable correctional health administrators to measure their facilities against those standards.

The initial answer came not from corrections but from the health professions. The first national health care standards drafted specifically for correctional institutions came from the American Public Health Association (APHA). Said to be applicable to both prisons and jails, the 1976 APHA standards addressed one of the problems noted above in that they provided more specificity than earlier sets of standards. They did not, however, address the problem of enforcement.

In 1977, the American Medical Association (AMA) published its first correctional health standards. This edition was specific to jails and, while not as detailed as those of the APHA, had the advantage of an accompanying accreditation effort that allowed facilities to be measured in terms of the extent of their compliance.[92] The AMA's jail standards were revised in 1978, 1979 and again in 1981, with each successive revision providing more direction and more detail based on the experience of applying these standards against actual delivery systems.

In 1979, the AMA published its first health care standards for prisons. It was not until 1982, though, that the first prison health system (at the Georgia State Prison in Reidsville) was accredited. Three more years would pass before the next prison health systems (13 units of the Texas Department of Corrections) were accredited. Significantly, litigation was a factor in both systems' accreditation.[93]

Before leaving this section, it should be noted that the American Correctional Association (ACA) did revise its standards for adult institutions in 1977 and again in 1981, and used the standards of the American Medical Association (AMA) as a base for its health care section.[94] In addition, the ACA also developed an accreditation effort for prisons that included a review of health services. As noted in Chapter XII, however, there are some important differences in terms of how the correctional and medical accreditation programs operate.

E. Current Efforts to Improve Prison Health Care

Since *Newman v. Alabama* was heard in 1972, literally hundreds of class action suits have been filed (usually under Section 1983 of the Civil Rights Act) on behalf of state prisoners alleging unconstitutional

conditions including health services. In its 1990 "Status Report", the National Prison Project of the American Civil Liberties Union noted that there were only five states where no litigation against the prison system existed for unconstitutional conditions.

Shansky (1989:2) suggests that with respect to health services, "a review of the last 20 years of litigation has shown that where constitutional deficiencies have been identified, certain patterns of problems have been described." He states there are four areas of deficiencies that courts have regularly recognized as demonstrating deliberate indifference: cases alleging lack of inmates' access to medical services, those charging a deficiency in follow through of needed health care, those maintaining that resources were not sufficient to provide adequate care, and those arguing that negative outcomes of care were preventable.

In most of the major class action suits, both sides have retained medical experts. Ken Faiver, who has served as the correctional health administrator for both Michigan and Puerto Rico, believes that:

> *In the majority of class action lawsuits involving allegations of inadequate health care, the parties have chosen to negotiate a consent agreement rather than go to trial for adjudication of the constitutional question. When this happens, the professional health care experts retained by the parties generally tend to agree on the major issues, though they sometimes quibble endlessly over certain details. Stated another way, the band of difference of opinion among qualified health care experts is relatively narrow.*
>
> *The decision makers for the defendants, however, usually include corrections administrators, attorneys, and fiscal staff who are less willing to agree to costly improvements. Often an immense expenditure of resources is made by the governmental entity in resisting, delaying, challenging, or only partially complying with the requirements of the court. In the face of such resistance, some judges have appointed a special master or court monitor to oversee compliance with court orders* (Personal communication, May 1990).

The role of the master in effecting change can be an important one. According to Nancy Dubler, an attorney who publishes frequently on correctional health topics:

> *Masters provide expert assistance to the court in the institution. In some cases, the appointment of a master has been found to be essential to achieving compliance with the court's orders (see e.g., Lightfoot v. Walker). Masters can and do further not only the interests of the inmate patients at whose behest they are usually appointed, but also the interests of the entire medical staff. Their recommendations lead to increases in resources and administrative reforms that empower medical units as they compete for their fair share of the budget* (Personal communication, March 1990).

There is no question that litigation can be an effective strategy for improving correctional health services. Indeed, some correctional administrators (although seldom publicly) welcome such suits as a way to obtain dollars otherwise denied to them and as a way to provide a cap on their population size. Nevertheless, while litigation may be an effective strategy for reform, it is seldom an efficient one. It may take years, even decades, for legal actions against government entities to accomplish their intended results and at extraordinary cost to the taxpayers.[95]

There is a less costly, less rancorous, yet equally effective approach to improving correctional health care; namely, voluntary compliance with national professional standards. According to Vincent M. Nathan, who has served as a special master for federal district courts in Ohio, Georgia, Texas, New Mexico and Puerto Rico:

> *No serious student of American correctional history can deny that litigation has provided the impetus for reform of medical practice in prisons and jails; likewise, no one who has been a judge, a litigating attorney, or a special master in a case involving correctional medical care can argue that meaningful reform is possible in the absence of the human and scientific resources of medicine. Indeed, the standards of medical care in jails and prisons adopted by the American Medical Association and the American Public Health Association have, to a large extent, translated the vague legal rulings of the courts into practical and viable tests for measuring the*

legal adequacy of institutional health care programs (1985:3-4).

Organizations such as the AMA, APHA and now the National Commission on Correctional Health Care have made significant contributions not only in improving prison health care delivery, but in upgrading the quality of health professionals serving in correctional medicine as well. The involvement of these groups and others has meant that correctional health professionals no longer need apologize for where they choose to work.

The American Public Health Association continues its long standing interest in correctional health care. Its standards were revised in 1986 (Dubler, ed.) and contain numerous references and legal citations that are of interest to correctional health professionals. Additionally, APHA has an active Jail and Prison Health Committee (which is part of its medical care section) that offers papers on correctional health topics at the annual APHA meetings. APHA also is represented on the board of directors of the National Commission on Correctional Health Care (NCCHC).

The American Correctional Health Services Association (ACHSA) -- an organization that evolved out of a meeting of prison health administrators in 1975 -- also is active today. ACHSA is a multi-disciplinary membership organization whose current enrollment totals about 1500 correctional health professionals. ACHSA is affiliated with the American Correctional Association and offers correctional health workshops at the ACA's annual meetings as well as holding its own conference each spring. Further, ACHSA publishes a bi-monthly newsletter, "Corhealth," for its members and is represented on the NCCHC board.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently discovered corrections as a potential market for its ambulatory care standards. Long the leader in accreditation of community health facilities, JCAHO has accredited some of the few prison hospitals in the past.[96] Now, however, it hopes to extend its efforts to correctional clinics and infirmaries as well. At this writing, ambulatory health services in only one jail and four prisons are known to be JCAHO accredited.

In the opinion of many, though, the dominant organization in correctional medicine today is the National Commission on Correctional Health Care (NCCHC) -- in part, because it consolidates the efforts of so many professional associations[97] and in part, because it offers so many diverse activities aimed at helping correctional institutions upgrade their health services.

An outgrowth of the American Medical Association's program, NCCHC was incorporated in 1983 and began conducting business as the National Commission on Correctional Health Care in January 1984.[98] The sole purpose of NCCHC is to improve health care in correctional institutions (prisons, jails and juvenile facilities), which it does by:

- continuing its accreditation program under revised standards;[99]
- offering on-site technical assistance at the request of the courts or facilities themselves;
- providing health-related training in such areas as receiving screening and suicide prevention to correctional staff;
- holding an annual conference that offers continuing education credits to the hundreds of correctional health professionals in attendance;
- performing quality reviews of prison health records;
- developing an AIDS education program for incarcerated youth (under a cooperative agreement with the Centers for Disease Control);
- disseminating monographs and manuals on correctional health care topics;
- distributing a quarterly newspaper, *CorrectCare*, free of charge to over 15,000 readers;
- assuming sponsorship of the *Journal of Prison and Jail Health* in 1989; and
- initiating a certification program for correctional health professionals in 1990.

F. Conclusions

While both litigation and the assistance offered by the health professional associations have resulted in significant improvements in the status of prison health care in the various states, some problems remain. Nonetheless, it is refreshing to note that the pressing problems of today are not the same as those of the 1970s. That, in and of itself, represents growth.[100]

In the 1970's, the primary concern was that prisons lacked adequate health delivery systems and that inmates' access to care often was blocked by correctional personnel. Now, it is rare to find state systems where inmates serve as caregivers; most health workers in corrections are appropriately licensed, registered and/or credentialed; correctional staff are far less apt to impede inmates' access to health care or to deny it overtly as punishment; and virtually every state department of corrections has some sort of health delivery system in place. The challenges for the 1990s include "...how to fine tune those systems so that the quality of care offered will mirror that of the community" (Anno, 1989), how to cope with population increases that put pressure on existing delivery systems and how to control burgeoning health care costs. It is toward these ends that the remainder of this book is directed.

ENDNOTES

1. The outline and format of this chapter as well as some of the content have been taken from Anno, 1981.
2. Account of a business woman who had been sentenced to a week in the Cook County Jail for contempt of court.
3. Portrait of an inmate called "Billy", which the author asserts is a "composite of real people" encountered in his study of prison health care.
4. This concept is discussed in more detail in section B.1 of this chapter.
5. See e.g., *Price v. Johnson* (1948).
6. In 1846, a small group of physicians met in New York to consider forming a professional association. The next spring, a larger group of physicians met in Philadelphia and officially formed the American Medical Association (AMA). At this meeting, May 2, 1848 was chosen as the date for the AMA's first annual session (Burrow, 1963).

A review of the transactions from that first session revealed that the AMA had adopted the following resolution:

> *Resolved, That the Committee on Public Hygiene be requested to investigate the effects of confinement in prisons and penitentiaries, and of the discipline in general, in those institutions, on the health of their inmates, and report to the next meeting of the Association* (AMA, May 1848:44).

As fascinating as it was to discover that the AMA had articulated a concern for inmates' health the year after its formation, no further concern was expressed officially for the next eighty-two years. The study called for in that early resolution apparently was never conducted -- at least there is no mention of such a report in the Proceedings of the House of Delegates in subsequent years.

The next official action of the AMA concerning prisoners' health care occurred in 1930. At that annual session, the House passed a resolution supporting a report of the American Bar Association's Committee on Psychiatric Jurisprudence, which called for the availability of psychiatric services to courts and to penal and correctional institutions (AMA, June 1930:41). Ten years later, the AMA voted to table a resolution supporting a plan for the creation of a training program in legal psychiatry -- which was an outgrowth of the 1930 resolution (AMA, June 1940:67).

The Proceedings of the House of Delegates from 1940 through 1968 include occasional references to "crime" or "prisoners" -- for example, in 1952 a resolution expressing disapproval of the participation of inmates in scientific experiments was adopted (AMA, December 1952:90-92, 109-110) -- but nothing further regarding correctional health care. Thus, the few statements that the AMA made regarding the plight of prisoners from 1848-1968 were simply statements of principle and were not accompanied by any programs seeking remedies.

Even the AMA's involvement in the Joint Commission on Correctional Manpower and Training (JCCMT) from 1966-1969 did not result in any action and the JCCMT reports include very little reference to health care personnel (see JCCMT, 1969 and 1970). In fact, the AMA's role in this

organization was so low-profile that there was no mention of it in any of the accounts of the AMA's official actions (e.g., the various Proceedings of the House or Digests of Official Actions) and most AMA staff -- including the person who initiated the Jail Program -- were unaware of the AMA's participation (Personal interview, Bernard P. Harrison, April 1981).

7. For example, Goldsmith (1975) titled his book "Prison Health" even though in his Preface he noted that "this book focuses on health care in jails." A similar situation obtained in Susan Alexander's article (May 1972) where the term "prison" was used to include jails as well.

8. See e.g., Clark (1971:40-51).

9. In distinguishing jails from prisons, Menninger says "Both are wretched, abominable institutions of evil, but generally the jails are by far the worse" (1969:44). Indeed, the belief that there was a positive relationship between the level of government and the level of services provided meant that the earliest efforts to improve correctional health care were most often directed at jails, since they were believed to be the most in need.

10. See The President's Commission (1967d:233-237) and (1967b).

11. See The President's Commission (1967d:211-231) and (1967c).

12. See e.g., Clark (1971:42-43).

13. See LEAA (February 1971).

14. See LEAA (January 1973, Table 2:160-322).

15. An AMA representative was invited to participate in the National Conference on Corrections held in Williamsburg, Virginia in 1971. Following the informal exchanges at that conference, the AMA conducted a small telephone poll of a cross-section of jail administrators. The results of that poll revealed a lack of available medical resources in jails as well as a generally positive response toward organized medicine as a source of amelioration (AMA, December 1974:3-4).

16. AMA (1973:1-2).

17. *Ibid.,* p. 12.

18. *Ibid.,* p. 20.

19. *Ibid.,* pp.20, 28.

20. *Ibid.,* p. 14.

21. See LEAA (1974) and (1975). The LEAA survey of 3, 291 jails revealed that only "one out of every eight jails had some sort of in-house medical facility" (1974:8); only 19 percent had a doctor on staff and of those, only a third served on a full-time basis (1975:10); only a third had facilities to treat drug addicts (1974:9); and finally, fewer than 18 percent indicated the availability of counseling programs for mentally ill inmates (1974:9).

22. See Woodson and Settle (1971); Kentucky Public Health Association (1974); Medical and Chirurgical Faculty of the State of Maryland (1973); Baker, DeMarsh and Laughery (1971); Report of the Medical Advisory Committee on State Prisons (1971); Office of Health and Medical Affairs (1975); and Health Law Project (1972).

23. See e.g., *Newman v. Alabama, Holt v. Sarver, Guthrie v. Evans, Burks v. Teasdale and Ruiz v. Estelle.*

24. See Rector (1929).

25. *Ibid.,* pp. 24-26.

26. AMA (1973:26).

27. Report of the Medical Advisory Committee on State Prisons (1971).

28. Woodson and Settle (1971).

29. Kentucky Public Health Association (1974).

30. Health Law Project (1972:87-88) and Kentucky Public Health Association (1974).

31. For example, one study reported that prior to the Attica uprising, the prison doctors had conducted sick call from behind a mesh screen -- hardly what can be called adequate "hands-on" care (Attica:1972). See also the report of the Medical and Chirurgical Faculty of the State of Maryland (1973) and the report of the Office of Health and Medical Affairs (1975) especially pp. 26f, 301f, 312, 314 and 335f.

32. Report of the Medical Advisory Committee on State Prisons (1971).

33. Kentucky Public Health Association (1974).

34. Office of Health and Medical Affairs (1975).

35. See e.g., Health Law Project (1972:136-138); Report of the Medical Advisory Committee on State Prisons (1971).

36. Office of Health and Medical Affairs (1975:226) and Anno (1977).

37. Health Law Project (1972:97) and Office of Health and Medical Affairs (1975:225-226).

38. According to the National Advisory Commission on Criminal Justice Standards and Goals (1973:343), fully half of the state maximum security institutions in use in 1970 had been built in the nineteenth century.

39. See e.g., Walker and Gordon (1977) and the cases cited therein.

40. Health Law Project (1972:23).

41. Office of Health and Medical Affairs (1975:80). The 1975 Michigan study also reported:

> *Birds are a chronic problem in the [housing] unit with at least a dozen sparrows noted flying through*

the cell block with nests apparent within the cell block area. The windows to the cell block are open during the warmer periods to provide some ventilation for the area and the windows are not screened creating an entry area for the birds. Since ventilation is limited for the area and at times the windows must be opened, steps should be taken to screen the windows at this time to minimize entry of the birds. On some levels pigeons have nested on exterior sills with noticeable pigeon and other birds droppings apparent. Since pigeon droppings could result in transmission of certain infections, a bird control program is needed for the building as well as all entries to the building being restricted to birds (Office of Health and Medical Affairs -- Technical Supplement, p. 127).

Even in the prison hospital, birds and other animals constituted a problem of note:

[Examples of] inadequate building and equipment maintenance signifying an almost complete lack of preventive or corrective maintenance [include] ...pen. tions in pipe chases, holes in wall or screens, windows lacking screens, all permitting access and propagation of insects, rodents and birds. Evidence of all this was seen in various locations (Office of Health and Medical Affairs, pp. 323f).

Pigeon habitation outside windows, particularly the operating room suite, risks the danger of contamination intake from their droppings through window air conditioners as well as loose fitting or open windows (Office of Health and Medical Affairs, p. 325).

42. See e.g., *Gates v. Collier, Pugh v. Locke.*
43. AMA (1973:30-31).
44. In "Medicine behind bars," it was reported that "Budgets are grossly inadequate to sustain nutrition" (as noted in Alexander, 1972:21).
45. The 1972 jail census phrased its question regarding meals as: "Is a hot meal usually served at least once a day to inmates?" (LEAA, 1975: Appendix II, 5) Hence, it is impossible to tell whether one or more than one hot meal per day was the norm.
46. A case in point was a concoction called "grue" -- a mishmash of meat, potatoes, eggs, margarine and syrup -- that was routinely served to inmates in isolation in the Arkansas prison system (see *Holt v. Sarver*, 1970).
47. LEAA (1971:4).
48. Gettinger (March 1976:9-20).
49. The situation today regarding crowding is not better and in some cases, is worse. The number of adults held in state and federal prisons has continued to rise every year since 1975 and the back-up of state and federal prisoners in county jails continues (see Potter, 1980:25 and Bureau of Justice Statistics, 1989). Further, the National Prison Project of the ACLU reported that as of January, 1989, 43 states (plus the District of Columbia, Puerto Rico and the Virgin Islands) were operating under court orders because of violations of the constitutional rights of prisoners owing to the conditions of their confinement and/or overcrowding (reported in one or more institutions in 39 state prison systems).
50. For an excellent summary and critique of psychological research on crowding, see Ruback and Innes (1988).
51. See e.g., McCain, Cox and Paulus (1980).
52. See e.g., Nacci, Teitelbaum and Prather (1977).
53. See e.g., American Medical Association/ American Public Health Association "*Amicus* brief" (1981) and the references cited therein.
54. See e.g., Gaes (1985) and Ruback and Innes (1988) on violence and stress research and Anno (1985) on suicide. While some studies have reported that suicide rates are higher in crowded facilities, it is erroneous to assume that crowding increases suicides. In fact, the opposite is more likely to be true, since multiple occupancy units reduce the opportunity for successful suicide. Two national surveys seven years apart reported that the majority of inmates committed suicide while in isolation. See Hayes and Kajdan (1981) and Hayes and Rowan (1988).
55. See e.g., Abeles, Feibes, Mandell and Girard (1970); King and Geis (1977); and Stead (1978).
56. See e.g., Walker and Gordon (1980).
57. For example, until more recently, few of the Texas Department of Corrections (TDC) prisons had outside yards. It was not uncommon for inmates to serve their whole sentence (whether two, ten or twenty years) without going outside. (Personal interviews with numerous TDC inmates during 1981).
58. According to a 1977 survey responded to by 163 major correctional institutions, while the vast majority reported offering both educational and vocational programs, only a third of the inmates were enrolled in the former and less than 20% were enrolled in the latter (Hindelang *et al.*, eds., 1980:148).
59. See Van Alstyne (1968).
60. See Goldfarb and Singer (1973:365-366).

61. See Zalman (1972:185-189).
62. See Goldfarb and Singer, 1973:371.
63. South Carolina Department of Corrections (1972:148). See also, *Coppinger v. Townsend, Cates v. Ciccone, Willis v. White.*
64. The Walnut Street Jail in Philadelphia usually is cited as the first American correctional facility, although Durham (1989) makes a strong case for other predecessors.
65. For an excellent historical discussion of the use of prisons in America, see Rothman (1971). See also Eriksson (1976). See Ignatieff (1978) for a historical review of the use of the penitentiary in England.
66. During the 1970s, the concept of rehabilitation of offenders began to lose favor based on several studies that examined the effectiveness of correctional treatment. For different sides of the debate, see e.g. Adams (1974), Bailey (1971), Carlson (1978), Fogel (1975), Frank (1979), Hawkins (1976), Lipton, Martinson and Wilks (1975), Martinson (1974), McKelvey (1977), Messinger (1977), Morris (1974), Palmer (1975), Riley and Rose (1980), Robinson and Smith (1971), Ross and McKay (1979), Von Hirsch (1986) and Wilkins (1975).
67. See Berk and Rossi (1977), Louis X. (Holloway) (1980) and Wright (1973) for discussions of the politics of punishment (i.e., who goes to prison and why).
68. See Zald (1968).
69. See Sykes and Messinger (1971).
70. See Goldsmith (1975:19-21).
71. The overwhelming majority of nurses and nurse practitioners are women. Further, the number of women physicians is increasing steadily and women are represented in all other health professions. Aside from the illegality of such a policy, Brecher and Della Penna note the absurdity of a refusal to hire women as follows:

> *In an era when securing competent health care personnel is exceedingly difficult, no correctional institution should deliberately hamper its own recruitment efforts by rejecting on principle one half of the human species. Women bring to a correctional health care service a humanizing influence which it urgently needs. If a correctional health care facility is in fact unsafe for female personnel, it is probably unsafe for male personnel as well, and steps should be promptly taken to make it safe for personnel of both sexes* (1975:56).

72. It should be acknowledged that many correctional physicians would disagree with this assessment. They like the diagnostic challenge that correctional medicine presents and state that they encounter more pathology in prison than they would in private practice.
73. Goldsmith (1975:21-23).
74. See Brecher and Della Penna (1975:71).
75. The passage of Medicare and Medicaid legislation and the number of bills pending in Congress on national health insurance were a reflection of this trend during the 1960s and 1970's.
76. See e.g., Attica (1972:251-257); Sykes (1958); McGraw and McGraw (1954); and Anno (1972).
77. Personal interview, November 15, 1972 as noted in Anno (1972).
78. See Hawkins (1976:42) and the authors cited therein.
79. See e.g., National Advisory Commission on Criminal Justice Standards and Goals (1973:37).
80. While there were few studies by 1970 that documented the incidence of communicable diseases among correctional populations, available medical evidence suggested that certain types of offenders were more likely to have communicable diseases than others (e.g., hepatitis among drug addicts and venereal disease among prostitutes and homosexuals). Further, these same individuals were less likely to have received prior medical care. These assumptions -- that inmates were a higher risk population for having communicable diseases and that these illnesses often were not identified, and thus, not treated -- were borne out by later studies (see e.g., Goldsmith, 1975; Anno, 1977 and 1978; Jones, 1976; and King and Desai, 1979).
81. According to data from a 1983 survey with responses from 30 states, the mean time served in prison was 20.5 months and the median was 13 months. Thus, even those convicted of felonies were returning to their communities in less than two years (Jamieson and Flanagan, 1987:410).
82. In his 1978 article, Stead reported evidence not only of intramural transmission of tuberculosis within Arkansas prisons, but evidence of transmission to the community as well. A former inmate infected his wife and two children, one of whom later died.
83. See Kurtzberg, Safer and Mandell (1969).
84. A few jurisdictions deserve credit for taking early and definitive steps forward without any prompting by the courts, achieving significant and comprehensive improvements in their prison health care services during the late 1970s. The Michigan Department of Corrections is one example. Central

among such innovations introduced in Michigan in 1975 was a departmental reorganization conferring significant autonomy on a newly created Office of Health Care, whose director reported immediately to the director of the DOC and supervised all institutional health care staff and resources. Unfortunately, a few years later, efforts to expand these improvements, especially with respect to mental health services, were deterred by hard economic times. Subsequently, however, a federal suit was introduced that resulted in a consent agreement and provided the leverage to move forward with further necessary improvements.

85. See e.g., National Clearinghouse for Criminal Justice Planning and Architecture (March 1976).

86. See Newman *et al.* (1976).

87. See GAO (April 1976).

88. Numerous evaluation studies were conducted by Anno and by Anno and Lang during the course of the program's funding. For a brief summary of these evaluation results, see Anno (1982).

89. Some of the CHCP manuals are still in print and can be obtained from the National Commission on Correctional Health Care at 2105 N. Southport, Suite #200, Chicago, Illinois 60614. Telephone (312) 528-0818.

90. For more information on the CHCP grant, see Lindenauer and Harness (1981).

91. In discussing the United Nations attempt to set standards for correctional practices, the NACCJSG noted that "usually they are broad, idealistic and ignored." (1973:356)

92. The first jails were surveyed for accreditation under the AMA's standards in August 1977 and 16 were awarded this distinction.

93. The impetus for health care accreditation in the prisons in both Georgia and Texas was at least partially attributable to Mr. Vincent M. Nathan, an attorney who served as the special master in both the *Guthrie* and *Ruiz* cases.

94. The ACA also had an LEAA grant to develop standards and an accreditation program and since it and the AMA grant both had the same project monitor (Mr. Nick Pappas), some coordination of efforts was achieved.

95. The *Ruiz* case in Texas is a prime example. Originally filed in 1972, it was still on-going in 1991. Beside the hundreds of millions of dollars spent in court-ordered reforms, it has cost the state millions in attorneys' fees (which it was required to pay for both sides) and millions to pay for the services of the court-appointed master and his monitors. The *Costello* case in Florida has had similar longevity.

96. There are only a handful of acute care hospitals serving prisoners exclusively. The federal prison system has JCAHO accredited hospitals at its facilities in Springfield, MO and Rochester, MN and the Texas Department of Criminal Justice hospital in Galveston, TX also is JCAHO accredited. There may be other examples as well, but not many.

97. The National Commission on Correctional Health Care is a not-for-profit 501 (c) 3 organization whose board of directors is comprised of individuals named by the following professional associations:

American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physician Assistants, American Academy of Psychiatry & the Law, American Association of Public Health Physicians, American Bar Association, American College of Emergency Physicians, American College of Health Care Executives, American College of Neuropsychiatrists, American College of Physicians, American Correctional Health Services Association, American Dental Association, American Diabetes Association, American Dietetic Association, American Jail Association, American Medical Association, American Medical Record Association, American Nurses' Association, American Osteopathic Association, American Pharmaceutical Association, American Psychiatric Association, American Psychological Association, American Public Health Association, American Society for Adolescent Psychiatry, John Howard Association, National Association of Counties, National Association of County Health Officials, National District Attorneys Association, National Medical Association, National Sheriffs' Association, and The Society for Adolescent Medicine.

98. The founder of the AMA's Jail Program, Bernard P. Harrison, JD, also was the founder of the National Commission on Correctional Health Care. When the jail program terminated in November 1981, Mr. Harrison obtained a two year grant from The Robert Wood Johnson Foundation to explore the viability of continuing a national effort to improve correctional health care. That grant resulted in the formation of the National Commission on Correctional Health Care as a separate corporate entity and was the realization of an idea conceived a decade earlier (see Harrison, 1973).

99. The standards originally developed by the AMA were adopted by National Commission on Correctional Health Care and revised as follows:

Standards for Health Services in Juvenile Confinement Facilities (1984); *Standards for Health Services in Jails* (1987) and *Standards for Health Services in Prisons* (1987). NCCHC revises its standards about every five years.

100. Reform of prison health care was delayed so long, in large part, because what transpired "behind the walls" was hidden from public scrutiny. It is a welcome sign that many prison systems are "opening their doors," either voluntarily or through court directive, and are seeking relevant licensure, regulation and/or accreditation of their health care services through appropriate state and other outside agencies.

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CHAPTER III

THE LEGAL RIGHT TO HEALTH CARE IN CORRECTIONAL INSTITUTIONS

A. Introduction

It is now recognized that inmates have a constitutional right to health care grounded in the Eighth Amendment prohibition against cruel and unusual punishment. Over the last two decades, the scope and parameters of this constitutional right have emerged from a series of federal court decisions.[1] Although prison and jail conditions and practices still must be analyzed on a case-by-case basis to determine whether they pass constitutional muster, a wealth of judicial opinions afford guidance to health care planners, administrators and providers. This chapter outlines the parameters of the duty of care as defined by federal judicial precedent. Readers should bear in mind, however, that courts have defined only constitutional *minima*. Therefore, legal authority provides only the barest of foundations for a quality system of care.

B. The Constitutional Right To Care

Federal district courts first began to recognize the constitutional duty to provide medical treatment to inmates in the early 1970s. Faced with a rising number of prisoner petitions for relief from the conditions of their confinement, the courts struggled to find the proper standard of judicial review. The dilemma was well framed by one court, which stated:

> *Although the Federal Courts are very properly loath to interfere in the internal administration of prisons, and wide discretion is allowed prison officials in maintaining order and discipline, our constitutional duties require that the courts be ever vigilant to assure that the conditions of incarceration do not overstep the bounds of federal constitutional limitations.*

Campbell v. Beto, 460 F.2d 765, 768 (5th Cir. 1972), citing *Cruz v. Beto*, 405 U.S. 319, 92 S.Ct. 1079 (1972).

The recognition that incarceration precludes the usual private arrangement for medical care weighed heavily on the courts. These circumstances caused one early court to conclude that "having custody of the prisoner's body and control of the prisoner's access to medical treatment, the prison authorities have a duty to provide needed medical attention." *Ramsey v. Ciccone*, 310 F.Supp. 600 (W.D.Mo. 1970). The same court went on to state that "there is a constitutional duty to provide needed medical treatment to a prisoner because the intentional denial to a prisoner of needed medical treatment is cruel and unusual punishment, and violates the 8th Amendment to the Constitution of the United States." *Id.* at 605.

The *Ramsey* court, however, also was quick to echo the pronouncement of many courts that a failure to provide needed treatment based upon mere negligence, while perhaps stating a state law tort claim for damages, did not give rise to a constitutional violation. *Id.* at 605. This important distinction survives today and must be borne in mind by providers: one may escape constitutional liability and yet be responsible for damages under state law for simple negligence.[2]

Throughout the early 1970s, federal lower courts formulated a variety of rationales for intervening on behalf of prisoners alleging denials of medical care. Some courts chose to examine whether the conduct of state officials revealed an "abuse of discretion" in failing to provide medical care. *See Robinson v. Jordan*, 494 F.2d 793, 794 (5th Cir. 1974). Other courts found a right to medical treatment for prisoners in the due process clause of the Fourteenth Amendment and held that "under the totality of the circumstances, adequate medical treatment must be administered when and where there is reason to believe it is needed." *Mills v. Oliver*, 367 F.Supp. 77, 79 (E.D.Va. 1973); *see also Fitzke v. Shappell*, 468 F.2d 1072, 1076 (6th Cir. 1972) ("fundamental fairness and our most basic conception of due process mandate that medical care be provided to one who is incarcerated and may be suffering from

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This chapter was developed by Jacqueline M. Boney, Nancy Neveloff Dubler and William J. Rold.

serious illness or injury.")

Yet other courts, relying upon the cruel and unusual punishment clause of the Eighth Amendment, inquired whether the conditions of confinement "shock[ed] the conscious," or constituted "barbarous acts." *See Martinez v. Mancusi*, 443 F.2d 921, 924 (2d Cir. 1970). The imprecision of the standard of review was well-stated in *Holt v. Sarver*, 309 F.Supp. 362, 372-73 (E.D. Ark. 1970), *aff'd*, 442 F.2d 304 (8th Cir. 1971). In sustaining a claim that conditions and practices throughout the entire Arkansas penitentiary system, including conditions pertaining to the availability of medical and dental care, amounted to cruel and unusual punishment, the *Holt* court stated:

> *The term* [cruel and unusual punishment] *cannot be defined with specificity. It is flexible and tends to broaden as society tends to pay more regard to human decency and dignity and becomes, or likes to think that it becomes, more humane. Generally speaking the punishment that amounts to torture, or that is grossly imposed, or that is inherently unfair, or that is unnecessarily degrading, or that is shocking or disgusting to people of reasonable sensitivity is "cruel and unusual" punishment. And a punishment that is not inherently cruel and unusual may become so by reason of the manner in which it is inflicted.*

Id. at 380.

Although employing varied reasoning, federal courts intervened with increasing frequency especially when faced with "evidence of rampant and not isolated deficiencies which due to callous indifference subject inmates to...severe deprivations...." *Newman v. State of Alabama*, 503 F.2d 1320, 1330 n.14 (5th Cir. 1974). In *Newman*, inmates filing *pro se* challenged conditions in a number of Alabama prisons. The evidence on the subject of medical care detailed serious shortages of staff, equipment and supplies. Unsupervised inmate assistants administered treatment, gave medication, and even performed suturing and minor surgery. Medical records were described as "inaccurate, incomplete and not standardized." *Id.* at 1323. The evidence established that, owing to poorly organized lines of responsibility, doctors often were unaware of their responsibilities with respect to particular patients. Records revealed that emergency patients were left unattended for extended periods of time. *Id.*

The evidence also described terrible suffering. A quadriplegic endured a maggot-infested wound because of unchanged dressings.

> *Another patient, a geriatric rendered partially incontinent by a stroke, was required to sit day after day on a wooden bench beside his bed so that the bed would be kept clean. He reportedly fell from the bench and his legs, one of which was subsequently amputated, became swollen and blue. He died one day after the amputation.*

Id. at 1324. Not surprisingly, on this record neither the district court nor the appellate court hesitated to conclude that the plaintiffs had proven a constitutional violation in delivery of medical care.

Both *Newman* and *Holt v. Sarver*, above, established that "the concept of 'cruel and unusual punishment' is not limited to instances in which a particular inmate is subjected to a punishment directed at him as an individual." *Holt v. Sarver*, 309 F.Supp. at 372. Confinement itself within a given institution or system of institutions may amount to cruel and unusual punishment where the confinement is characterized by conditions and practices so bad as to be shocking to the conscious of reasonably civilized people. In the words of the *Newman* court:

> [T]*he causes of nontreatment or delays in treatment should trigger disapproval as strident as that prompted by the fact of non-attendance or delay. Second, the pitfalls identified are of such a nature as to render large-scale improvident treatment inevitable. The use of dangerously out-moded equipment and medical techniques threatens the welfare of every inmate upon whom such equipment and techniques are employed. Third, and in conjunction with the latter point, the record is replete with countless examples of inmates who are subjected to incalculable discomfort and pain as a result of the lack of medical care or inadequacy in the treatment administered. These examples fortify the conclusion that deficiencies were not isolated and bespeak of callous indifference to the*

welfare of inmate-patients. Moreover, these examples also belie any suggestion that suffering resulted merely from legitimate discrepancies of opinion as to the proper treatment to be rendered.

503 F.2d at 1332.

Based upon similar reasoning, in 1974 the Oklahoma state penitentiary system was found to provide unconstitutional conditions of confinement. With respect to medical care, the federal court held:

Actionable circumstances result where, as here, the level of medical care available to a confined and dependent population is inadequate to meet predictable health care needs because of obvious and sustained deficiencies in professional staff, facilities and equipment. When continued and systemic deficiencies of this nature exist and have resulted in the actual impairment of inmate health, and when such deficiencies continue to pose a current and potential threat to the physical health and well being of an entire prison population, then inmates are deprived of the basic elements of adequate medical treatment in violation of the Eighth Amendment, (citation omitted), and are also subjected to disabilities beyond those contemplated by incarceration, in violation of the due process clause of the Fourteenth Amendment.

Battle v. Anderson, 457 F.Supp. 719 (E.D. Okla. 1978).

The constitutional standard against which medical care for prisoners should be tested was addressed finally by the U.S. Supreme Court in *Estelle v. Gamble*, 429 U.S. 98, 97 S.Ct. 285 (1976). Gamble, an inmate of the Texas Department of Corrections, was injured while performing a prison work assignment. He alleged persistent denials of care as well as inadequate care and interference with care by security staff. The Supreme Court took the occasion of Gamble's petition to embrace the rulings of many lower courts that certain "[e]lementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration." *Id.* at 103, 97 S.Ct. at 290. The Court noted that in the worst cases, a failure of medical care might actually produce physical "torture or lingering death," citing *In re Kemmler*, 136 U.S. 436, 447, 10 S.Ct. 930, 933 (1890), and that even in less serious cases, "denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose." 429 U.S. at 103, 97 S.Ct. at 290. The Court further concluded that the infliction of unnecessary suffering is inconsistent with contemporary standards of decency, and held:

We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain" [citation omitted] *proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action....*

429 U.S. at 104-105, 97 S.Ct. at 291. The Court went on to clarify that "[i]n order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend "evolving standards of decency in violation of the Eighth Amendment." 429 U.S. at 106, 97 S.Ct. at 292.[3]

At the time, the *Estelle v. Gamble* opinion was criticized for describing the state's duty to provide adequate medical care to inmates in terms which might be construed to relate to the subjective motivation of persons accused of violating the Eighth Amendment. *Id.* at 109, 97 S.Ct. at 203 (Justice Stevens dissenting). Even before *Estelle v. Gamble*, however, federal appellate courts had recognized that a complaint need not allege that prison officials consciously sought to inflict pain on the prisoner by withholding treatment in order to state a constitutional claim. *See, e.g., Westlake v. Lucas*, 537 F.2d 857, 860, n.3 (6th Cir. 1976); *Runnels v. Rosendale*, 499 F.2d 733, 736 (9th Cir. 1974). Moreover, subsequent judicial interpretations of *Estelle v. Gamble* have not required prisoners to prove intent in order to plead a constitutional claim

for denial of medical care.

The *Estelle* decision reinforced the Supreme Court's prior pronouncement that "when a prison regulation or practice offends a fundamental constitutional guarantee, federal courts will discharge their duty to protect constitutional rights." *Procunier v. Martinez*, 416 U.S. 405, 94 S.Ct. 1800 (1974). The federal judiciary took heed, and prisoner complaints of denials of necessary medical care subsequently received careful judicial scrutiny. The next section describes the basic inmate rights that have emerged from the cases defining "deliberate indifference." Section D examines court rulings establishing the standards by which to measure health care in prisons, while section E reviews special issues and section F looks at recent developments in case law applicable to correctional health care.

C. Basic Rights Of Inmates

Three basic rights have emerged from the case law:

The right to access to care;
The right to care that is ordered; and
The right to a professional medical judgment.

Each right is discussed separately.

1. The Right to Access to Care

Courts have long recognized that denial of access to a physician for diagnosis of a serious ailment or one causing persistent pain, or an unreasonable delay in affording access, constitutes an unconstitutional denial of medical care. *Fitzke v. Shappell*, 468 F.2d 1072 (6th Cir. 1972)(alleged 17 hour delay in providing evaluation of head injury); *Todaro v. Ward*, 431 F.Supp. 1129, 1133 (S.D. N.Y. 1977), *aff'd*, 565 F.2d 48 (2d Cir. 1977); *Jones v. Lockhart*, 484 F.2d 1129 (8th Cir. 1973)(refusal of paramedic to provide treatment); *Thomas v. Pate*, 493 F.2d 151, 153 (7th Cir. 1974)(alleged refusal of doctor to treat allergic reaction and alleged delay in removing sutures while confined in unsanitary conditions). Access to care must be provided for any condition, be it medical, dental or psychological, if the denial of care might result in pain, suffering, deterioration or degeneration.

2. The Right to Care that is Ordered

It also is elementary that a constitutional violation is presented when needed prescribed care is denied to an inmate. *See Martinez v. Mancusi*, 443 F.2d 921 (2d Cir. 1970)(allegation that prison physician refused to administer prescribed pain killer, and rendered leg surgery unsuccessful by discharging the prisoner early from the infirmary and requiring him to stand contrary to instructions from the free world surgeon, if proven, would state a claim of unconstitutional deprivation); *Tolbert v. Eyman*, 434 F.2d 625 (9th Cir. 1970)(alleged denial of diabetes medication prescribed by free-world physician); *Campbell v. Beto*, 460 F.2d 765 (5th Cir. 1972)(alleged denial of prescribed heart medication and alleged requirement that prisoner perform manual labor despite contrary medical classification). Again, a breach of the constitutional duty may arise whether the denial is of ordered medical care, dental care, psychological care or restorative services.

3. The Right to a Professional Medical Judgment

Courts have long distinguished between cases alleging a complete denial of medical care and those where the claim is that the prisoner received inadequate medical treatment. If the prisoner has received some medical attention and the dispute is simply over the adequacy of the treatment, federal courts remain reluctant to "second guess" medical judgments or to constitutionalize claims that are really state tort law claims. It is recognized, however, that in some cases, "the medical attention rendered may be so woefully inadequate as to amount to no treatment at all." *Westlake v. Lucas*, 537 F.2d 857, 860, n.5 (6th Cir. 1976), citing *Tolbert v. Eyman*, 434 F.2d 625, 626 (9th Cir. 1970)(stating that "treatment so cursory as to amount to no treatment at all, may, in the case of serious medical problems, violate the Fourteenth Amendment").

Essentially, the right to a professional medical judgment involves assuring that:

> *[D]ecisions concerning the nature and timing of medical care are made by medical personnel, using equipment designed for medical use, in locations conducive to medical functions, and for reasons that are purely medical.*

Neisser (1977: 956-957). The enforcement of this right on behalf of inmate patients also serves, rather than detracts from, the professional independence of health care practitioners within the correctional setting.

Moreover, the federal courts' reluctance to "second guess" medical judgment has not precluded them from examining the competency of the provider. As early as 1972, allegations that medical care was provided by "persons not licensed to practice medicine in the State of Texas" were termed "serious." *See Campbell v. Beto*, 460 F.2d 765, 769 (5th Cir. 1972). In 1974, the absence of sufficient trained medical personnel, and the wide-spread use of untrained "medical technicians" and inmate assistants was found to pose a problem of "constitutional magnitude" in *Newman v. Alabama,* 503 F.2d at 1330. The use of inmates to provide medical care and shortages of qualified physicians, nurses and other medical personnel also contributed to findings of system-wide unconstitutional conditions in the provision of medical care in the states of Louisiana (*Williams v. Edwards*, 547 F.2d 1206 (5th Cir. 1977) and Texas (*Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980); *aff'd in part and rev'd in part*, 679 F.2d 1115 (1982), *am. in part, vac. in part,* 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042, 103 S.Ct. 1438 (1983). Similarly, the absence of a sufficient number of qualified medical staff contributed to findings of constitutional deficiencies in the Oklahoma state prison system (*Battle v. Anderson*, 457 F.Supp. 719 (E.D. Okla. 1978)), as well as at the Menard Correctional Center operated by the state of Illinois (*Lightfoot v. Walker*, 486 F.Supp. 504 (S.D. Ill. 1980)).

D. Providing A Constitutional System Of Care

As noted above, several courts have held that systemic deficiencies in staffing, facilities, equipment and procedures for ensuing access to care may amount to deliberate indifference. The state's basic obligations are summarized succinctly in *Capps v. Atiyeh*, 559 F.Supp. 894 (D. Ore. 1982), a case challenging conditions of confinement in the Oregon prison system. The court stated:

> *The State's obligation is three-fold. First, prisoners must be able to make their medical problems known... Second, the medical staff must be competent to examine inmates and to diagnose their illnesses. Third, staff must be able to treat the inmate's medical problems or to refer the inmates to outside medical sources who can.*

559 F.Supp. at 910, citing *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982).

Numerous courts, upon finding the institution's system of care constitutionally inadequate, have outlined in some detail the elements of a sound correctional health care system. For example, in *Lightfoot v. Walker*, 486 F.Supp. 504 (S.D. Ill. 1980), a case involving the Menard facility, the court identified the following elements:

- the selection of a chief of medical services with responsibilities for budget, health care planning and the supervision of all medical staff;
- a prompt medical history;
- the appropriate number of staff with the appropriate training to perform required medical services and dispense medication;
- a sick call procedure utilizing persons trained in physical diagnosis and triage and written procedures and protocols;
- the prescription, dispensing and administration of all medication under medical supervision;
- adequate laboratory and x-ray services;
- complete and adequate medical records, which are subjected to periodic review to determine compliance;
- emergency medical care, 24 hours a day, 7 days a week;
- effective and comprehensive in-service training programs;
- regularly scheduled clinic visits;
- a system for monitoring inpatients;

- the removal of any inmate assistants from the care of the patient; and finally,

- provision for the performance of both internal and external audits of medical services according to acceptable professional standards.

Other courts have focused in more detail on the components of a comprehensive health care delivery system.

1. Dental Services

It is well established that a correctional institution's failure to provide the dental services necessary to relieve pain or to restore function may result in a finding of unconstitutional care. Courts recognize, however, that a correctional clinic is not required to provide complete state of the art dentistry or the full range of dental services available to nonincarcerated persons. The scope of services required will turn, in part, on the length of the inmates' incarceration. A program sufficient to relieve suffering may be acceptable in a jail facility where the length of stay is short. A more expansive range of services, including restorative services, is required for institutions that house prisoners with extended sentences.

In *Dean v. Coughlin*, 623 F. Supp. 392 (S.D. N.Y. 1985), the court ruled that inmates had been denied dental care "on an institutional scale," *id.* at 404, justifying a class-wide court order. The evidence established that there was no functioning system for routine care and the process for providing emergency care had "broken down." *Id.* at 395. Among other things, the court ordered:

- Same day evaluation and treatment of emergencies;

- Appointments for non-emergency treatment within one week of a request;

- A priority system for the orderly treatment of patients according to the seriousness of their needs;

- A follow-up system that provides care as ordered and without delay; and

- A quality assurance and audit system.

2. Mental Health Services

The Eighth Amendment also protects against unnecessary serious psychological suffering. Indeed, as early as 1977 it was held that there is "[n]o underlying distinction between the right to medical care for physical ills and its psychiatric counterpart." *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977). The court went on to state that:

> *We therefore hold that* [the plaintiff] *(or any other prison inmate) is entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial. The right to treatment is, of course, limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable.*

Id. at 47-48.

A most comprehensive review of mental health care was provided in *Ruiz v. Estelle,* 503 F.Supp. at 1332-38. In that case, the court formulated six components of a minimally adequate mental health treatment program:

- a systematic program for screening and evaluating the inmates in order to identify those who require mental health treatment;

- treatment that entails more than segregation and close supervision of the inmate patient;

- treatment that requires the participation of trained mental health professionals who must be employed in

sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders;

- maintenance of accurate, complete and confidential records of the mental health process;

- a basic program for the identification, treatment and supervision of inmates with suicidal tendencies; and

- a ban on the prescription and administration of behavior altering medication in dangerous amounts by dangerous methods, or without appropriate supervision and periodic evaluation.

See also Balla v. Idaho St. Dept. of Corr., 595 F.Supp. 1558, 1577 (D. Idaho 1984); *Laaman v. Helgemoe*, 437 F.Supp. 269 (D.N.H. 1977).

Although many courts have recognized that the deliberate indifference standard of *Estelle v. Gamble* applies to claims against jails and prisons for failure to prevent suicide, decisions on this issue are inconsistent and it is difficult to articulate a single standard of care. A sample of recent decisions is presented.

In *Partridge v. Two Unknown Police Officers of the City of Houston*, 791 F.2d. 1182 (5th Cir. 1986), the court held that allegations of a deliberate and systematic lack of adequate care for detainees, resulting in a failure to take any steps to prevent a suicidal detainee from injuring himself, stated a claim against the municipality under §1983 of the Civil Rights Act.[4] The jail officials were informed of the detainee's fragile mental condition and previous nervous breakdown. The detainee also had a record within the jail showing that he had attempted suicide during an earlier confinement. The court held that to the extent the prisoner alleged a deliberate and systematic lack of adequate care for detainees on the part of the city, the case presented a possible constitutional violation that required trial on the merits.

Other courts, however, have imposed very heavy burdens upon plaintiffs. In *Molton v. City of Cleveland*, 839 F.2d 240, 243 (6th Cir. 1988), *cert. denied*, 489 U.S. 10689 (1989), the court held that deliberate indifference in a suicide case must amount to an intent to punish. A municipality must have a deliberate and discernible custom or policy to maintain an inadequately trained department or an inadequately designed and equipped jail. The court suggested that a plaintiff might establish such a deliberate policy or custom through evidence of gross neglect or recklessness. *See also Danese v. Asman*, 875 F.2d. 1239 (6th Cir. 1989), *cert. denied*, 110 S.Ct. 1473 (1990).

In *Belcher v. Oliver*, 898 F.2d 32 (4th Cir. 1990), jail officials, contrary to departmental directives, failed to remove a detainee's belt and shoes and failed to screen the detainee for suicidal tendencies. The inmate successfully hung himself with his belt. In dismissing the §1983 claim of constitutional deprivation, the court stated that the right to basic medical care does not include the right to be screened for suicidal tendencies, particularly where there is no indication or reason for the officials to suspect such tendencies on the part of the detainee. The court further held that the failure of jail officials to carry out established procedures for suicide prevention, without more, alleged negligence at most, and did not establish deliberate indifference. *See also Popham v. City of Talladega*, 908 F.2d 1561 (11th Cir. 1990).

Similarly, in *Burns v. City of Galveston*, 905 F.2d 100 (5th Cir. 1990), the court held that the failure to train police officers in screening procedures geared toward detection of detainees with suicidal tendencies does not rise to the level of constitutional deprivation, because detainees do not have an absolute right to psychological screening. The court drew a distinction between training officers to screen to detect "tendencies," and training them to recognize and not ignore "obvious medical needs of detainees with known, demonstrable and serious mental disorders." *Id.* at 104.

Liability is most likely to be found when an inmate's mental illness is known. In *Greason v. Kemp*, 891 F.2d 829 (11th Cir. 1990), a patient's anti-depressant medication was discontinued by the prison psychiatrist and the inmate subsequently committed suicide. The court of appeals held that the case presented a question of fact for the jury as to whether a §1983 violation had occurred. The court stated that in order to prove a claim, the plaintiff must show that grossly inadequate care was provided and that a reasonable person would have known that

such care constituted deliberate indifference to the needs of the inmate.

The court further held that where prison personnel directly responsible for an inmate's care have knowledge that the inmate has attempted or even threatened suicide, their failure to take steps to prevent the inmate from committing suicide can amount to deliberate indifference. Regarding the liability of supervisory employees, the court held that such liability depends on whether in failing to train and supervise subordinates adequately, the supervisor was deliberately indifferent to the inmate's mental health needs. Other considerations are whether a reasonable person in that position would have known that such failure reflected deliberate indifference, and whether the supervisor's conduct was causally related to the constitutional infringement by his subordinate.

The court stated that a supervisor's awareness of inadequate staffing and failure to do anything about such inadequate staffing could support a finding of deliberate indifference. In addition, a failure to notify competent officials of an inmate's dangerous psychiatric condition might constitute deliberate indifference, as could a failure to institute corrective procedures after a similar incident caused harm to another inmate. According to the *Greason* court, the director of mental health for the state department of corrections could be held liable under §1983 based on evidence that he had an awareness of conditions at the institution, including understaffing and inadequate training, that could lead to grossly inadequate mental health care, and he made no attempt to remedy the situation. The court stated that the warden of the institution also could be held liable on similar facts.

Looking at the reported decisions on suicide cases, it is clear only that judicial opinion has not yet come to full agreement on the legal obligation of corrections to prevent prisoner suicides. However, correctional administrators and prison health care providers may be guided by the apparent leanings of the courts with respect to the major factors in suicide prevention.

While suicide is a personal, deliberate, voluntary, self-imposed act, there are areas in prevention that increasingly are gaining the attention of the courts. Foremost may be the training of correctional officers in the rudiments of suicide prevention. An administration that provides reasonable training for its prison staff will have made a good stride against being found deliberately indifferent. Further, a prison that has a clear written policy on suicide prevention and an ongoing process for its implementation, will have substantially buttressed its defense against liability under §1983.

3. Special Diets

Several courts have recognized that medically ordered special diets are constitutionally protected. In the face of evidence that inmates inexplicably were not provided with special diets they admittedly were supposed to receive, one court held:

> *As a matter of law, the evolving standards of decency that mark the progress of a maturing society require prison officials to afford inmates special diets if prescribed for them. Regardless of the cost involved, there is simply no penological justification for depriving inmates with serious medical problems of their duly prescribed diets.*

Balla v. Idaho St. Board of Corrections, 595 F.Supp. 1558 (D. Idaho 1984). *See also Twyman v. Crisp*, 584 F.2d 352 (10th Cir. 1978); *French v. Owens*, 538 F.Supp. 910, 928 (S.D. Ind. 1982); *Johnson v. Harris*, 479 F.Supp. 333 (S.D.N.Y. 1979).

E. Special Issues In Correctional Health Care.

1. Confidentiality of Personal Medical Information

Although the United States Supreme Court has not ruled directly on the issue, there is a consensus among courts generally that the privacy of one's personal affairs is protected by the constitution. *See Woods v. White*, 689 F.Supp. 874, 876 (W.D. Wis. 1988), citing *Kimberlin v. United States Department of Justice*, 788 F.2d 434, 438 (7th Cir. 1986); *Plante v. Gonzalez*, 575 F.2d 119, 1134 (5th Cir. 1978), and relying upon *Whalen v. Roe*, 429 U.S. 589, 97 S.Ct. 869 (1977). Several courts have recognized that, although there are many invasions of the right to privacy inherent in the fact of incarceration, convicted persons retain "some constitutional right to privacy." *Torres v. Wisconsin Dept. of Health & Social Services*, 838 F.2d 944, 951 (7th Cir. 1988)(holding that female inmate's constitutional right to privacy did not conflict with employment rights of male correctional officers given procedures in place and

available to protect the inmate's privacy interests). At least two courts have held expressly that inmates have a constitutionally protected right to nondisclosure of medical records, while at the same time acknowledging that the right is not absolute. *See Doe v. Coughlin*, 697 F.Supp. 1234 (N.D. N.Y. 1988); *Woods v. White*, 689 F.Supp. 874 (W.D. Wis. 1988).

The United States Supreme Court has held that even the right to privacy of non-incarcerated persons may be overridden in support of public health goals under certain circumstances. Specifically, in *Whalen v. Roe*, the Supreme Court upheld a New York requirement for reporting the names and addresses of patients receiving certain prescription drugs and held that reporting requirements for public health purposes will not be found to be unconstitutional invasions of privacy if: (1) the information is reasonably related to a valid public health purpose; (2) access to the information is limited to public health departments and their officials; and (3) the reporting scheme has strict confidentiality protection. Moreover, the privacy rights of prisoners are not as extensive as those enjoyed by individuals outside of prison. *See, e.g., Pell v. Procunier*, 417 U.S. 817, 822, 94 S.Ct. 2800, 2804 (1974). In examining the constitutionality of certain mail and marriage restrictions, the United States Supreme Court has stated that where a prison regulation impinges upon an inmate's constitutional rights, the regulation is valid if it is "reasonably related to legitimate penological interest." *Turner v. Safley*, 482 U.S. 78, 107 S.Ct. 2275 (1987).

Extrapolating from the standard announced in *Turner*, the review of any prison policy or practice that permits the disclosure of medical information must include the following determinations:

- Whether there is a valid, rational connection between the disclosure and the legitimate governmental interest advanced to justify the disclosure;

- What impact the accommodation of the prisoner's interest in nondisclosure of medical information will have on the correctional staff and other inmates, and on the allocation of prison resources generally; and

- What other alternatives are readily available that would satisfy the penological interest, but would accommodate the prisoners' privacy right at *de minimus* cost to valid penological interests.

Applying this standard, the district court in *Doe v. Coughlin, supra*, barred the state of New York from involuntarily transferring HIV positive prisoners to a segregated dormitory specifically designated only for HIV positive inmates.[5] The court found that such transfers would result in a disclosure of confidential medical information, not only to prison staff and the general prisoner population, but also eventually to family members and friends. Although recognizing certain benefits to the segregation, such as savings in transportation costs and other logistical concerns associated with bringing prisoners to a specific medical center, the court found that these benefits were insufficient, standing alone, to warrant the infringement of the prisoners' rights. The court reasoned that the same objective could be served in a program designed to allow inmates to exercise choice over their participation. *See also Woods v. White, supra* (holding that casual, unjustified dissemination of confidential medical information respecting a prisoner's HIV status to non-medical staff and other prisoners stated a constitutional claim, and holding that the defendants could not assert qualified immunity in defense of the inmate's damage action).

A contrary result was reached in *Harris v. Thigpen*, however, 727 F.Supp. 1564 (M.D. Ala. 1990). The plaintiffs in *Harris*, as in *Doe v. Coughlin*, asserted that actions which permitted the spread of information that they were carriers of the HIV virus invaded their constitutionally protected right to privacy. The court rejected the claim. Taking note of the high cost to the state of caring for AIDS patients and also commenting that communication of the disease by one inmate to another might expose the state to liability as well as affect the public welfare, the court concluded that "[a]n inmate's infection with AIDS is, therefore, not a private matter, but a matter of controlling State interest." *Id.* at 1572. In upholding both segregation and mandatory testing, the court gave great weight to the rights of other prisoners and suggested that "[a]llowing inmates with AIDS to be introduced into the general population may be violative of the general population inmates' Eighth Amendment rights." *Id.*[6]

The court also based its ruling on its finding that there were "no alternative methods to protect the safety of other inmates and custodian officers and the security of the institution from the spread of the disease." *Id.* at 1574. At the time of writing this chapter, the *Harris v. Thigpen* decision was on appeal, but it is on this last point that the decision respecting segregation may be most vulnerable. A number of states, including Texas, have adopted policies that involuntarily segregate only those prisoners who have tested positive for the HIV antibody and who have engaged in sexual activity or other conduct that might actually result in transmission. Such measures recognize the extant medical evidence respecting transmission, and yet preserve and respect the constitutional rights of infected inmates who act responsibly. Some correctional systems, such as Vermont's and Mississippi's, make condoms available to inmates as a means of transmission prevention.[7]

Even outside the prison setting, there are instances in which a provider may have not only a right, but a duty to report or disclose confidential medical information to third parties. For example, in *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334 (Cal. 1976), the California Supreme Court ruled that in some circumstances, therapists have a duty to warn third parties against injury or harm by a patient. The *Tarasoff* court concluded that a psychotherapist's revelation of a patient's communication is not a violation of professional ethics where such a disclosure is necessary to avert danger to others. The court stated:

> *We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.*

Id. at 347.

This duty, where recognized by state law,[8] would be equally applicable in a prison setting. It should be noted, however, that the *Tarasoff* court cautioned that "the therapist's obligation to his patient requires that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger." *Id.* (emphasis added).

2. Consent to Treatment and the Right to Refuse

The doctrine of informed consent for medical treatment (including the right to refuse treatment) has long been incorporated into American jurisprudence and is uniformly recognized by state common law. The United States Supreme Court has recognized that the right to refuse unwanted medical treatment also is protected by the Fourteenth Amendment of the United States Constitution. In *Cruzan v. Missouri Department of Health*, 58 LW 4914 (June 25, 1990), the Court acknowledged that a "competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."

The issue of an inmate's right to consent to treatment and correspondingly, to refuse treatment, was first examined by the United States Supreme Court in *Vitek v. Jones*, 445 U.S. 480, 100 S.Ct. 1254 (1980). In *Vitek*, a prisoner challenged, on procedural due process grounds, a Nebraska statute that permitted the transfer of a prisoner to a mental hospital if a designated physician or psychologist found the prisoner to be suffering from a mental disorder that could not be given proper treatment in prison. The Supreme Court determined that the "stigmatizing consequences" of a transfer to a mental hospital for involuntary psychiatric treatment, combined with the subjection of the prisoner to mandatory behavior modification as a treatment modality, constituted a deprivation of a liberty interest that required procedural due process protection. The Court affirmed the lower court's finding that the following minimum procedures were required before transferring a prisoner to a mental hospital:

- Written notice to the prisoner that a transfer to a mental hospital is being considered;
- A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied upon for the transfer and at which an

opportunity to be heard in person and to present documentary evidence is given;

- An opportunity at the hearing to present testimony of witnesses by the defense and to cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination;
- An independent decision maker;
- A written statement by the fact finder as to the evidence relied on and the reasons for transferring the inmate;
- Availability of a competent and independent adviser who is free to act solely in the inmate's best interest;
- Effective and timely notice of all the foregoing rights.

See Vitek, 445 U.S. at 494-500, 100 S.Ct. at 1264-1268.

In *Baugh v. Woodward*, 808 F.2d 333 (4th Cir. 1987), the court considered whether a *Vitek* procedural hearing was required prior to an inmate's transfer to an inpatient mental health facility. The court concluded that the hearing properly could be held after the patient's transfer, based upon evidence that before the actual admission to the inpatient facility and before treatment commenced, an evaluation would be conducted. The court concluded that there was sufficient time prior to the commencement of treatment in which to provide the hearing.

In *U.S. v. Jones*, 811 F.2d 444 (8th Cir. 1987), the court considered whether a full *Vitek* procedural hearing was required prior to the temporary transfer of prisoners to another prison to facilitate psychiatric and psychological evaluation. The court concluded that a temporary transfer for a psychological evaluation places no more of an imposition on a prisoner than does a transfer for administrative reasons and therefore, determined that the due process clause does not prohibit such a transfer or require a pre-transfer hearing.

The issue of an inmate's right to consent to treatment and correspondingly, to refuse treatment, is presented most frequently in the context of an inmate's objection to the forced administration of psychotropic medication. In *Washington v. Harper*, ___ U.S. ___, 110 S.Ct. 1028 (1990), the Supreme Court recognized that inmates possess a "significant liberty interest" under the due process clause of the Fourteenth Amendment in avoiding the unwanted administration of anti-psychotic drugs. *See also U.S. v. Watson*, 893 F.2d 970 (8th Cir. 1990), holding that federal prisoners, like involuntary mental patients, have a constitutionally protected liberty interest in freedom from bodily restraint that extends to the right to refuse psychotropic medication. *Id.* at 977.

The due process clause in the Fourteenth Amendment also has been found to afford convicted prisoners "a limited [constitutional] right to refuse treatment and a related right to be informed of the proposed treatment and viable alternatives" with respect to general medical care. *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990). In explaining the prisoner's right to be informed of the proposed treatment and the viable alternatives, the court stated:

> *A prisoner's right to refuse treatment is useless without knowledge of the proposed treatment. Prisoners have a right to such information as is reasonably necessary to make an informed decision to accept or reject proposed treatment, as well as a reasonable explanation of the viable alternative treatments that can be made available in a prison setting.*
>
> *We can recognize that prison doctors' task* [sic] *in communicating with their patients may be difficult. Prisoners' questions may range from reasonable to obstructionist. Prisoners may not bring treatment to a halt, insisting on answers to questions that are unreasonable, time-wasting or intended to turn the doctor/patient relationship into a battle for control over treatment.*

Id. at 113.

The inmate's right to be informed must be balanced against valid state interests, but where the state has no valid interest in denying the right to

know, a constitutional claim is stated. Accordingly, the court held that if inmate White could prove his allegations that he was allergic to penicillin, and that the physician refused to disclose to him whether a proposed injection contained penicillin, and thereafter instituted disciplinary proceedings against him for refusing the injection, he would establish a constitutional deprivation. *Id.* at 113.

In *Washington v. Harper, supra*, the Supreme Court examined the "due process" protections that must be afforded to inmates before psychotropic drugs can be administered against their will. The case arose from a policy of the Washington Department of Corrections that permitted forced treatment with anti-psychotic drugs of inmates who were found (1) to suffer from a "mental disorder", and (2) were "gravely disabled" or posed a "likelihood of serious harm" to self, others or their property. In examining the adequacy of the procedural protections afforded by the state policy, the Court asked whether the regulation was "reasonably related to legitimate penological interest" citing *Turner v. Safley, supra.* The Court in *Washington* held:

> [G]*iven the requirements of a prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.*

___ U.S. at ___, 110 S.Ct. at 1040-41.

The Court went on to approve the procedural protections afforded by the state of Washington, which required:

- Approval of the medication by a psychiatrist;
- An opportunity for a hearing at the patient's request, to be held before a committee comprised of a psychiatrist, psychologist and administrator, whose members could not be involved in the patient's diagnosis or treatment at the time of the hearing;
- An opportunity for the patient to attend the hearing, to present evidence, to cross-examine witnesses, and to have the assistance of a knowledgeable lay advisor; and
- A right under state law to obtain judicial review, such as through a petition for an extraordinary writ, of the hearing committee's decision, and a record of the administration proceeding adequate to allow such review.

Id. at 1044. The Court specifically rejected the inmate's contentions that he was entitled to initial judicial review, that the hearing should be conducted in accordance with the rules of evidence, that a "clear, cogent and convincing" standard of proof was required, or that the prisoner was entitled to representation by legal counsel. *Id.* at 1040-44.

While the *Washington v. Harper* decision provides fairly clear guidance regarding the procedural protections that must be afforded before anti-psychotic drugs may be administered against a prisoner's will, the threshold issue of whether the inmate poses a danger to himself or others may require further judicial scrutiny. In *U.S. v. Watson*, 893 F.2d 970 (8th Cir. 1990), a case decided before the Supreme Court's opinion in *Washington* was issued, it was held that the Federal Bureau of Prisons could forcibly medicate a prisoner if such medication was necessary to release him from segregation and permit his safe return to the general population. The court expressly rejected the argument that an inmate who can function adequately in segregated confinement should have the right to choose segregation and be free of forced treatment with psychotropic medication. *Id.* at 982. In so holding, the court also rejected the notion that the prisoner had the right to be provided the least restrictive treatment modality, which he asserted to be segregation in lieu of medication. *Id.*

It remains to be seen whether this pre-*Washington* decision will be followed or upheld in light of the *Washington* requirement that the inmate first be found to be dangerous to self or others. Is an inmate who poses no threat to himself or others while confined in segregation nonetheless "dangerous to himself and others?" Using the standard of *Turner v. Safley*, one certainly could argue that where the state's penological interest can be satisfied by

confining a prisoner in segregation, the prisoner's desire to be free of forced treatment should be respected.

It also remains to be seen whether the right to refuse medical treatment when the refusal of treatment will result in death will be afforded to inmates now that the United States Supreme Court clearly has afforded that right to competent adults. *See Cruzan v. Missouri Department of Health, supra.* The only reported pre-Cruzan opinion to reach the issue held that a prisoner does not have the unrestricted right to refuse medical care where the refusal is likely to result in death. In *Comm'n. of Correction v. Myers*, 399 N.E.2d 452 (Mass. 1979) the Supreme Court of Massachusetts permitted forced hemodialysis treatment of a patient upon proof that (1) without the treatment the prisoner would die and (2) with the treatment the prisoner could lead an otherwise normal life. The court applied a balancing test. While noting that a non-incarcerated person might be permitted to refuse treatment under such circumstances, the court concluded that the state's interest in upholding orderly prison administration tipped the balance in the direction of authorizing treatment without consent. *Id.* at 457.

The court adopted the state's contention that its failure to prevent Myers' death would present a serious threat to prison order and security. The state maintained first, that prisoners would not be able to understand why Myers had been allowed to die and this fact alone could be "explosive." Second, since Myers' avowed reason for refusing treatment was his desire to be transferred to a minimum security facility, the state contended that a failure to force treatment would encourage prisoners to "attempt similar forms of coercion in order to attain illegitimate ends." *Id.* One could conclude that a different decision might be reached if the prisoner's grounds for refusing treatment were based on more primary considerations such as the pain or other side effects of the treatment. The outcome also might change if the condition soon would cause death regardless of any medical treatment.

F. Recent Developments

1. Contracts with Private Providers Do Not Avoid Constitutional Liability

In recent years, many prison systems have chosen to contract with private physicians or organizations to provide care rather than to use state employees. Law suits alleging inadequate medical treatment in violation of the Eighth Amendment right to be free from cruel and unusual punishment typically are brought under §1983 of Chapter 42 of the United States Code. To prevail in such an action, the inmate must show that the defendant was acting "under color of state law." When faced with §1983 suits, private providers contended that they were not acting "under color of state law," and therefore, were not liable under §1983.

This issue was brought before the United States Supreme Court in 1988 in the case of *West v. Atkins*, 487 U.S. 42, 108 S.Ct. 2250 (1989). The defendant in the case was a private physician under contract with the state of North Carolina to provide orthopedic services at a state prison hospital. Inmate West alleged that the physician had acknowledged that surgery was necessary for a leg injury but had refused to schedule it, and had discharged the prisoner while his ankle was still swollen and painful. The issue presented was whether the private physician had "acted under color of state law."

The Supreme Court concluded that the private physician's delivery of medical treatment was state action fairly attributable to the state, and that the defendant therefore acted under color of state law for purposes of §1983. The Court analyzed the state's liability as follows:

> *The fact that the State employed* [the doctor] *pursuant to a contractual arrangement that did not generate the same benefits or obligations applicable to other state employees does not alter the analysis. It is the physician's function within the state system, not the precise terms of his employment, that determines whether his actions can fairly be attributed to the State. Whether a physician is on the state payroll or is paid by contract, the dispositive issue concerns the relationship among the State, the physician, and the prisoner. Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights. The State bore an affirmative obligation to provide adequate medical care to* [the prisoner]; *the State delegated that*

function to [the private doctor]; *and* [the private doctor] *voluntarily assumed that obligation by contract. Id.* at 2259.

2. Abortion

In *Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326 (3rd Cir. 1987), inmates challenged a county regulation that required both a specific court-ordered release and independent sources of funding before a woman could secure an abortion. The inmates challenged the regulation on two grounds: (1) that the regulation constituted an unconstitutional infringement upon the inmates' right to elect to terminate their pregnancies as guaranteed by *Roe v. Wade*, 410 U.S. 133, 93 S.Ct. 705 (1973); and (2) that the regulation constituted deliberate indifference to a serious medical need and therefore violated the Eighth Amendment.

The court agreed with both of the inmates' contentions. In analyzing the Eighth Amendment claim, the court concluded that an elective, nontherapeutic abortion may constitute a "serious medical need," because denial or undue delay in provision of the procedure would render the inmate's condition "irreparable." The court went on to analyze the county regulation under the reasonableness standard of *Turner v. Safley*, discussed above. On the facts presented, the court found the regulation unreasonable. The court concluded that denying an inmate an abortion served no legitimate penological interest. The court stated "the County's policy is simply inexplicable in terms of legitimate security concerns." *Id.* at 338. Specifically, the court noted that inmates needing other types of medical care were not required to secure their release before receiving such services. The court went on to note that the inmates had no alternative means of exercising their right, since delay would serve to preclude the exercise of the right to an abortion.

The court's analysis of the impact accommodation of the inmates' constitutional right would have on correctional officers and other inmates centered primarily on the cost of performing the abortion, including transportation costs. The court acknowledged that existing case law established that the government cannot be forced to finance abortions for poor women outside of prison. The court noted, however, that requiring payment for abortion imposed no greater burdens than already existed under the county's responsibility to provide all pregnant inmates with proper pre- and post-natal care. The court observed that whether the state provided the medical care associated with the full term pregnancy or provided funds for an abortion, the use of a prison's limited resources was virtually the same. Therefore, the court concluded that in the absence of alternative methods of funding, the county must assume the cost of providing inmates with elective, non-therapeutic abortions.

3. Environmental Conditions

Several cases have recognized that conditions of confinement that expose inmates to communicable diseases and identifiable health threats implicate the Eighth Amendment guarantee against cruel and unusual punishment. See, e.g., *Jones v. Diamond*, 636 F.2d 1364, 1374 (5th Cir. 1981) *cert. dismissed*, 453 U.S. 590, 102 S.Ct. 27 (1981)(holding that constant and habitual exposure of convicted prisoners to persons who are contagiously ill is cruel and unusual punishment). Such cases are being relied upon to support inmate petitions for a smoke-free area of confinement.

At least one circuit court has held that allegations of indefinite confinement in a small cell with a smoker against a non-smoker's expressed will may violate the Eighth Amendment's prohibition against cruel and unusual punishment. Specifically, in *Clemmons v. Bohannon*, 718 F.2d 858 (10th Cir. 1990), the court held that the inmate was entitled to present evidence as to whether long term exposure to environmental tobacco smoke poses an unreasonable risk to his health. The court noted that "the mounting scientific evidence of the potentially lethal effects of long-term exposure to tobacco smoke raises a genuine fact issue whether the type of exposure potentially faced by a non-smoking prisoner double-celled with a smoker constitutes a health hazard at least as significant as denial of exercise." *Id.* at 865. *See also Avery v. Powell*, 695 F.Supp. 632 (D.N.H. 1988).

An Indiana district court, however, reached the contrary conclusion and stated that the Constitution provides inmates with no guarantee of protection from environmental tobacco smoke. *Gorman v. Moody*, 710 F.Supp. 1256 (N.D. Ind. 1989). The *Gorman* court noted, however, that as "our society moves toward a so-called smoke-free environment and new laws are enacted, there may come a time when the 'evolving standards of decency that mark

the progress of society,' demand a smoke-free environment in a prison setting." *Id.* at 1262. Moreover, the *Gorman* court recognized that a constitutional claim is stated when an inmate alleges that a diagnosed serious medical condition is exacerbated by environmental tobacco smoke, and where a doctor's recommendation for placement in a non-smoking area is not followed. *See, e.g., Beeson v. Johnson,* 668 F.Supp. 498 (E.D.N.C. 1987).

The law on this issue is clearly in a developmental stage. Nonetheless, correctional administrators would be well advised to consider reasonable measures to accommodate non-smokers. The protections offered at the U.S. Penitentiary at Marion, Illinois were favorably commented upon in *Caldwell v. Quinlan,* 719 F.Supp. 4 (D.C. 1990), and provide useful guidance. The Marion policy provided the following protections: (1) conference rooms, elevators and the library area were designated "non-smoking;" (2) the dining hall was divided into smoking and non-smoking areas; (3) inmates could determine whether workplaces were smoking or non-smoking; and (4) two housing areas were designated non-smoking, and non-smokers who requested a non-smoking area were accommodated on a space available basis.

4. AIDS

The AIDS crisis has generated several troublesome legal issues, and in many respects the law remains unsettled. The cases discussed below provide some guidance.

a. Non-Consensual AIDS Testing

Two challenges to non-consensual AIDS testing of prisoners have reached the federal appellate courts, but the issue has not yet reached the United States Supreme Court. In *Dunn v. White,* 880 F.2d 1188 (10th Cir. 1989), a prisoner alleged that prison officials had assaulted him and threatened to place him in disciplinary segregation when he refused to submit to a blood test for AIDS. The prisoner contended that coerced, non-consensual AIDS testing violated his rights under the Fourth Amendment to be free from unreasonable search and seizure. The court examined the prisoner's Fourth Amendment claim under the standards set forth in *Turner v. Safley, supra.* It sought to determine whether the policy was supported by a legitimate governmental interest, and whether there was a valid and rational connection between the non-consensual testing program and the governmental interest advanced to justify it.

The court in *Dunn* found that, even without specific evidence, "the district court could take judicial notice of the seriousness and the potential for transmissibility of the disease AIDS." *Id.* at 1195. The court further found that, even absent evidence that AIDS infection is wide-spread among prisoners, the state's attempt to ascertain the extent of the problem would itself be a legitimate penological purpose. The court went on to state that "the prison, as caretaker, has an interest in diagnosing and providing adequate health care to those already infected with AIDS." *Id.* at 1198. The court thus concluded that the prison's substantial interest in pursuing a program to treat those infected with AIDS and in taking steps to prevent further transmission of AIDS, outweighed the plaintiff's expectation of privacy. The court further concluded that the connection between a non-consensual AIDS testing program and the state's goal of treating and preventing the spread of AIDS was "not 'so remote as to render the policy arbitrary or irrational'", citing *Turner v. Safley,* 42 U.S. at 89-90, 107 S.Ct. at 2262. *Id.* at 1198.[9]

In contrast, the Ninth Circuit Court of Appeals reversed a district court ruling affirming prior to trial the authority of prison officials to take non-consensual blood samples, allegedly in order to determine if any prisoners were carriers of the AIDS virus. *See Walker v. Sumner,* 917 F.2d 382 (9th Cir. 1990). Like the *Dunn* court, the court in *Walker v. Sumner* applied the standards set forth by the Supreme Court in *Turner v. Safely, supra.* The *Walker* court, however, held that prison authorities could not rely on general and conclusory assertions to support their policies.

> *Rather, they must first identify the specific penological interests involved and then demonstrate both that those specific interests are the actual bases for their policies and that the policies are reasonably related to the furtherance of the identified interests. An evidentiary showing is required as to each point.*

917 F.2d at 386 (emphasis added). The *Walker* court found a complete absence of evidence as to why the

officials conducted the mandatory blood tests, and also found a complete absence of evidence as to what, if anything, the prison officials intended to do with the information they obtained. On this record, the appellate court found that it was not proper to rule in favor of the prison officials, and the case was therefore remanded to the district court for a presentation of evidence by both sides.

b. Required Treatment

Suits have been filed in New York, California, Connecticut, Florida, Nevada, Alabama and Idaho alleging inadequate medical care for HIV-infected inmates. Only a handful of cases have actually been decided, but some guidance can be gleaned from these decisions.

In *Maynard v. New Jersey,* 719 F.Supp. 292 (D.N.J. 1989), the family of a deceased inmate brought suit against prison medical personnel for failure to diagnose, and an alleged refusal to treat an inmate's condition resulting from HIV infection. The parents alleged that the prisoner received only an over-the-counter pain preparation and throat lozenges despite evidencing persistent symptoms typically associated with the AIDS virus. The prisoner allegedly was not treated until he collapsed in the prison, whereupon he was transferred to a hospital and died eleven days later of AIDS.

The *Maynard* court noted with approval precedents which hold that medical personnel may not "opt for" an easier and less officious treatment of the inmate's condition with deliberate indifference to the prisoner's serious medical needs. *See Monmouth County Correctional Institution v. Lanzaro,* 834 F.2d 326 (3d Cir. 1987). The court found that the allegations made by the prisoner's family were sufficiently specific and evidenced such a serious medical need that the claims, if proven, would constitute a violation of the Eighth Amendment. This opinion teaches correctional medical personnel the importance of providing educated and sensitive attention to the symptoms of the AIDS virus, and a prompt and appropriate medical response when such symptoms are evidenced.

The duty of correctional officials to provide an appropriate level of care for highly symptomatic HIV-infected prisoners was addressed in *Gomez v. U.S.,* 899 F.2d 1124 (11th Cir. 1990). The case was heard on appeal from a district court ruling releasing a prisoner from federal custody based upon a finding that the treatment of the prisoner, who had stage IV AIDS, was inadequate at a correctional facility with only an infirmary. The circuit court found that the district court had exceeded its authority by ordering the prisoner's release. The court stated that the proper relief would have been a mandatory injunction to bring the prisoner's treatment up to constitutional standards, which could have been accomplished by transferring the prisoner to the federal facility at Springfield, Missouri. The case is important because it stands for the proposition that federal courts will require remedial measures, including transfer to a hospital, when an inadequate level of care is provided to a symptomatic HIV-positive prisoner.

Only one reported decision has addressed the duty of a state correctional system to provide the drug zidovudine (AZT) for treatment of non-symptomatic HIV-positive prisoners. In *Wilson v. Francheschi,* 735 F.Supp. 395 (M.D. Fla. 1990), a prisoner challenged a correctional physician's failure to prescribe AZT at a time when the prisoner was HIV-positive but non-symptomatic. The court found that during the period in question, the correctional system provided AZT only to prisoners who had an actual diagnosis of AIDS or were acutely ill. The court found in favor of the correctional physician on the grounds that, for the particular time period in question, the policy was consistent with the guidelines of the Centers for Disease Control as well as the manufacturer's guidelines, and that it was only later that the medical community came to realize the efficacy of providing AZT to asymptomatic prisoners who tested HIV-positive. Because the record showed that the prisoner had been given AZT after the Centers for Disease Control's and the manufacturer's recommendations changed in August of 1989, the court denied the plaintiff's claim. Although the plaintiff in *Wilson* lost, the court's opinion suggests that a different result would have been reached if the correctional system had failed to provide AZT after that point in time at which the medical community realized its benefit for asymptomatic HIV-positive patients.

c. Segregation of Prisoners Testing HIV-Positive

As discussed above, most courts have denied constitutional challenges brought by HIV-positive prisoners who have been involuntarily segregated.

See discussion in section E.1. of this chapter and endnote 5.

On the other hand, courts also have denied claims by non-HIV-positive prisoners asserting that their Eighth Amendment rights are violated by a state's failure to identify and segregate HIV-positive prisoners. *See Glick v. Henderson*, 855 F.2d 536 (8th Cir. 1988); *Janik v. Celeste,* 1991 U.S. App. Lexis 5327 (6th Cir. 1991); *Hilaire v. Arizona Dept. of Corrections,* 1991 U.S. App. Lexis 11620 (9th Cir. 1991); *Cameron v. Metcuz,* 705 F.Supp. 454 (N.D. Ind. 1989); *Feigley v. Fulcomer,* 720 F.Supp. 475, 480-82 (N.D. Pa. 1989). Generally, in rejecting the claim that a prison's failure to identify and isolate HIV-positive prisoners constitutes cruel and unusual punishment to non-infected prisoners, the courts simply have deferred to the decision of the prison administration.

d. Therapeutic Trials

Inmates with HIV infections increasingly are seeking access to therapeutic clinical trials and this issue also may be ripe for litigation. Research interventions often provide the best care from the most knowledgeable and astute university staff. Until recently, the federal regulations governing research on human subjects generally were thought to preclude most research on inmates.[10] A special section of those regulations makes it difficult to conduct research, but not impossible. Nonetheless, inmates who desire access to therapeutic clinical trials could be accommodated by protocols that pay particular attention to the prison setting in order to ensure the most voluntary and uncoerced consent possible to trials designed for those conditions not amenable to accepted treatment.[11]

G. Conclusions

A government's obligation to provide medical, dental and psychiatric care for those whom it is punishing by incarceration is now well established. Institutions must develop an organized system of care that guarantees each inmate's right of access to care when needed, guarantees that medically ordered care is in fact provided, and ensures that a professional medical judgment respecting the need for care is afforded.

Further, an inmate's right to confidentiality respecting medical matters must be accommodated absent a legitimate governmental interest in the disclosure that cannot be satisfied through other available means. Similarly, an inmate's right to consent to treatment and the corresponding right to refuse treatment will be protected within certain limits and are subject to procedural due process safeguards.

Judicial precedent provides clear benchmarks for the development of a constitutionally adequate system of health care. The best measures of an appropriate system of care, however, continue to be found in the contemporary community standards of the various medical professions. It is to these standards and requirements that correctional health care planners, administrators and providers should look for guidance in their daily endeavors.

ENDNOTES

1. For a discussion of the historical emergence of this right, see Chapter II, sections B1 and C4. Inmates in certain states also may have a right to receive health care based upon either state constitutional or statutory provisions, or based upon state judicial opinions. However, because of the supremacy of the U.S. Constitution, the majority of the case law defining the rights of inmates to receive health care has issued from federal courts and is based upon interpretation of the U.S. Constitution. This chapter is devoted primarily to a discussion of federal judicial precedent.

Readers should bear in mind that the federal judicial system has three tiers. The district court is the federal court of original jurisdiction in which litigation begins. District court decisions may be appealed to a court designated as the circuit court. Circuit court decisions, in turn, may be appealed to the U.S. Supreme Court, the highest court in the land.

Both the federal district courts and the circuit courts are organized geographically. Smaller states generally comprise a single district; other states are divided into two or more districts. Multiple districts are combined into geographically designated circuits, of which there are thirteen, designated the First through the Eleventh, the District of Columbia and the Federal Circuit.

Decisions handed down by the U.S. Supreme Court control all districts. The decisions of a particular circuit (appellate) court control in all districts within the circuit. A decision from one circuit may be considered persuasive in another circuit, but it is not binding. Likewise, a decision of

a district court is not binding on other district courts. Therefore, when there are decisions on particular issues among circuits or districts, and the Supreme Court has not yet decided the point, one may wish to focus on the decisions of the particular circuit in which the correctional facility is located.

Correctional health care providers are encouraged to seek advice from their respective attorneys general regarding applicable state laws, as well as the proper application of the case law discussed in this chapter.

2. Although the *Ramsey* case is noteworthy for the legal principles it articulated, the petitioning inmate was found to have failed to prove his claim, as both the prison official and outside consultant concluded that the prisoner's diagnosis and course of treatment were proper.

3. Although *Estelle v. Gamble* is widely cited as a landmark victory for prisoners' rights, Gamble, in fact, lost his claim. Relying upon evidence in the record that Gamble had been seen by medical personnel on 17 occasions over a three month period, the Court found that Gamble had failed to prove a constitutional violation. The Supreme Court concluded that the record, at most, presented evidence of medical malpractice, a claim which Gamble would have to pursue in state court under state law. *Id.* at 109, S.Ct. at 293.

4. The rights of arrestees and pre-trial detainees are determined under the due process clause of the Fourteenth Amendment to the U.S. Constitution rather than the Eighth Amendment, which applies only to persons convicted of a crime. It has been generally recognized, however, that pre-trial detainees are entitled to at least the level of care set forth in *Estelle v. Gamble, supra,* and the deliberate indifference standard therefore is applied to claims of constitutional deprivation by pre-trial detainees. *See, e.g., Partridge v. Two Unknown Police Officers of the City of Houston,* 791 F.2d 1182 (5th Cir. 1986).

5. An earlier challenge in the state of New York to the segregation of AIDS patients brought under the equal protection clause and the Eighth Amendment had failed. In *Cordero v. Coughlin*, 607 F.Supp. 9 (S.D.N.Y. 1984), the court held that the equal protection clause required only that "similarly situated people be treated equally." Since AIDS patients carried a virus that was fatal and incurable and highly transmittable, the court found they were not similarly situated to other prisoners. The court further found that the state had a legitimate objective: the protection of AIDS patients and other prisoners from the tensions and harm that could result from the fears of other inmates. The court further found that the segregation of the infected inmates was a rational means to reach the state's objective. *Id.* at 10. Since *Cordero*, equal protection challenges to the practice of segregating inmates testing positive for the HIV antibody generally have been unsuccessful. *See e.g. Powell v. Dept. of Corrections, State of Okl*, 647 F.Supp. 968 (N.D. Okl. 1986) (holding that the equal protection requirement is met if all known carriers of HIV are treated equally and classification is not arbitrary); *Judd v. Packard*, 669 F.Supp. 741 (D. Md. 1987) (upholding placement in isolation in medical setting, on medical order, of suspected carriers of the HIV antibody for diagnostic and treatment purposes); *Harris v. Thigpen*, 727 F.Supp. 1564, 1570 (M.D. Ala. 1990) (holding that the state has a legitimate end and segregation is rationally related to that end). The *Cordero* court also rejected an Eighth Amendment challenge to the segregation, which asserted that such segregation was cruel and unusual punishment because of its psychological effects. *Id.* at 11.

6. The *Thigpen* court also rejected the contention that inmates were entitled to a hearing before being segregated. The court held that where a medical test has demonstrated that the inmate is the carrier of a serious disease, "the reason for confinement is apparent and there is no occasion for a hearing." 727 F.Supp. at 1573.

7. See Moini and Hammett (1990: 42).

8. *See, e.g., Bardoni v. Kim,* 151 Mich. App. 169, 390 NW2d 218 (1986); *Peck v. Counseling Service of Addison County, Inc.,* 146 Vt. 61, 499 A. 2d 422 (1985); *Lipari v. Sears, Roebuck & Co.,* 497 F.Supp. 185 (D.Neb. 1980) (construing Nebraska law); *McIntosh v. Milano,* 168 N.J.Super. 466, 403 A.2d 500 (1979).

9. The *Dunn* court also rejected the prisoner's challenge to the policy under the First Amendment, finding that the plaintiff had made only a vague assertion that he refused AIDS testings on generic "religious grounds." 880 F.2d at 1198. Further, the court rejected the prisoner's due process claim that he was entitled to a hearing because the prisoner alleged only a threat of segregation and not an actual attempt to segregate. *Id.*

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CHAPTER IV

ETHICAL CONSIDERATIONS AND THE INTERFACE WITH CUSTODY

A. Introduction

Like their peers in the community, correctional health providers are bound by the ethics of their particular professions. The ethical imperatives (e.g., protection of confidentiality of the patient/provider relationship, respect for patient centrality of the process of informed consent) remain the same regardless of the setting. There are circumstances, however, where the correctional setting poses ethical dilemmas for the correctional health provider for which there are no parallels in the community (e.g., requests to perform body cavity searches, collect forensic information, or pronounce death at an execution). There also may be times -- despite restrictions imposed by the doctrine of confidentiality -- when it may be appropriate for correctional health professionals to provide custody staff with limited medical information about a specific inmate.

This chapter explores in greater detail some of the ethical issues that should be considered by correctional health professionals. It begins by introducing a number of the basic ethical principles in medicine, describes some of the unique ethical dilemmas posed by the correctional setting and concludes with a brief discussion of some of the circumstances when it is appropriate to share limited medical information with custody staff. Specifically, Sections B and C below both begin with a brief sketch of how the ethical issues are framed and presented in general bioethics and contrast this usual analysis with the particular conditions, strictures and law that apply in correctional institutions. Section B addresses issues and principles in biomedical ethics including special characteristics of the prison setting, the doctor/patient relationship, informed consent and the right to refuse care, confidentiality, research, and terminal care and advance directives. Section C presents bioethical issues unique to correctional settings such as participation in body cavity searches, collecting forensic information, witnessing use of force, using restraints for non-medical reasons, monitoring disciplinary segregation inmates, managing hunger strikes and participating in executions. Section D discusses the role of health services with respect to other custody functions such as classifying, disciplining and transferring inmates. A brief summary statement is included in Section E.

B. Issues and Principles in Biomedical Ethics

Biomedical ethics is a field of inquiry largely honed over the last two decades and developed out of a combination of explorations of moral philosophy and ethical principles, case law opinions and clinical commentaries based on actual cases. It has investigated, among other areas, the nature of the doctor/patient relationship; the quality, extent and power of patient authority; the process of informed consent and refusal; physician beneficence; and the use, misuse, control and possible abuse of medical technology. In addition, bioethical analyses, both legal and ethical, have explored specific areas in depth such as a woman's right to control her body (including abortion, maternal-fetal conflict and forced cesarean sections); neonatology; the ethics of treatment for children and adolescents; research on human subjects with particular emphasis on especially vulnerable populations including prisoners; genetic engineering; new reproductive technologies; termination of care; and access to care.

This selected list illustrates some of the issues, populations and processes that have been the focus of bioethical scholarship. A vast literature provides the background for this discussion of ethical dilemmas in correctional health care.

1. Special Characteristics of the Prison Setting

Much of this particular ethics discussion is new to the literature, but is certainly not new to the field of correctional health care in which practitioners struggle to define and fulfill their ethical obligations to patients in an atmosphere that sometimes threatens or attempts to intimidate or affect professional judgment. Care providers report that it requires constant vigilance, self-awareness and periodic reexamination to avoid being co-opted by and developing an identification with correctional authorities, their goals, modes of thinking,

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This chapter was developed by Nancy Neveloff Dubler and B. Jaye Anno.

conception of and relationship to inmates. This feeling of alliance with correctional authorities is problematic, because the medical model often is fundamentally at odds with the correctional model. This dissonance should be recognized and respected. Both points of view should be taken into account when making policy.

The purpose of medicine is to diagnose, comfort and cure; the purpose of prisons, although sometimes rehabilitative, is to punish through confinement. These often mutually incompatible purposes provide the background for the interaction of correctional and health professionals and help explain why ethical dilemmas, even in well-managed correctional settings, are inevitable. They must be anticipated and examined thoughtfully by professionals in structuring and supervising health services and while providing care to inmates. Medicine generally is practiced in an office, clinic or hospital where the goals of patient care define, or should define, the administration, organization and process of care. Correctional medicine is practiced in alien space where the custody philosophy is predominant and the practice of medicine is viewed, at best, as a necessary support for good administration and, at worst, as a barely tolerated interference with the ultimate authority of the warden. Further, neither setting is organized for the public health issues that frequently confront correctional health staff.

Respect for patients and regard for their well-being must be the primary posture for health care providers. Biomedical ethics is premised on the proposition that the patient's choice is central, because the patient has the overwhelming moral authority or moral agency in matters affecting his/her body and mind; but the very foundation of a correctional philosophy is that someone other than the inmate has the ultimate say over his/her behavior, movement and personal decisions. It would require a perverse genius to construct a setting, philosophy, operation, staffing and control as inimical to the assumptions of medical ethics as correctional facilities.

The requirement for ethical behavior attaches to physicians, nurses, physician extenders, dentists, psychologists and all other clinicians. This does not mean that other professionals do not have ethical obligations. Lawyers, journalists and businessmen, among others, all struggle to define what is proper behavior given the particular stresses, pressures and situations they confront. Health care providers, however, have been the subject of more intensive and extensive discussion because health care affects more people than other professions. Thus, the issues in health care are more widespread and better known, the dissonance of technological development more apparent, the consumer movement more active and the severity of the issues -- often life or death -- more easily grasped.

Inmates, moreover, are not passive in this process. They regularly press for access to the health unit as a non-correctional, and therefore, theoretically more humane, activity. Not only is the health care staff expected to respond to requests for primary and ambulatory care and to make appropriate referrals to clinical specialists, but also to evaluate and respond to other requests of inmates that have nothing to do with health services (e.g., requests for different shoes, religious or ethnic diets, or intervention with security staff).

Inmates often turn to the health care staff for the expression of emotions that they are unwilling or unable to share with correctional staff. Inmates may visit a health care facility as a route to escape from boredom, a place to meet friends in a more relaxed and less supervised setting, or as a way of escaping from the monotony of work and programs that continue unrelentingly and are unresponsive to individual daily choice. A health service not only treats the sick, but also provides the possibility, as many inmates see it, for the exercise of individualism, autonomy and choice. This identification of the health service as a place different from others in an institution places a great burden on the health staff.

Health care providers are asked to address an overwhelming list of needs and wants that inmates present to them, many of which realistically they cannot meet. Given budgetary realities and the previously noted often forced alliance between health care professionals and correctional authorities, the usual dilemmas of medical care are exacerbated by security limitations. Often both groups -- caregivers on the one hand and inmates on the other -- are frustrated and disappointed. Inmates feel their needs are unmet; health staff feel inappropriately used or, perhaps, manipulated by inmates whose treatable medical problems may not be the primary reason for requesting assistance. There is another reason for tension between inmates and caregiving staff. While important federal court opinions and the work of professional associations have provided the basis for vastly improved quality in correctional health services in many parts of the country, there are still institutions in which the quality of care remains low. Many inmates know that they are entitled to health care, but fail to understand how that right has been

explained and limited by the Supreme Court and the federal courts. Furthermore, overcrowding has exacerbated all previously existing problems. As prisons and jails become jammed far beyond their planned capacity, the population produces more sick call visits than reasonably can be handled by the available health care staff. Many medical facilities simply are overwhelmed by the numbers. This explains, but does not excuse, turning away a medically needy inmate, or delaying follow-up or consultant care, or doing only a cursory assessment when a more thorough evaluation is indicated.

Finally, and perhaps most important of all, in the words of a lifer, "everything hurts more in prison." As connections with the outside world are severed, the individual's focus naturally turns inward. Ailments and discomforts, which may provide only a moderate distraction outside of prison, become overwhelming and all important for incarcerated persons. Why should an inmate struggle to continue working or to meet a deadline when the reward and benefits structure that promotes this behavior in society is absent? Inside of prison, there is no reason for the inmate to ignore whatever symptom is causing stress; "muddling along" and fighting against symptoms to keep going make no sense in prison.

2. The Doctor/Patient Relationship; Beneficence and Autonomy

The doctor/patient relationship, and its extension to all providers, is defined by mutual respect and, on the part of the patient, comfort and trust. This trust is grounded in knowledge that the physician is bound by the most basic ethic of medicine, "do no harm," and will be the advocate for what is in the "best interest" of the patient. Problems often arise when the physician's judgment regarding what is in the best interest of his or her patient conflicts with the patient's preference and choice.

Patient autonomy -- what the law calls self-determination -- is another important premise of medical ethics. Support for individual patient choice does not mean that countervailing factors, particularly physician beneficence and paternalism, do not exist, but rather that in a contest between patient autonomy and the wishes of others (even if weighty), the patient's preference will prevail, absent very special circumstances. This theme suffuses and grounds bioethical discussions outside of corrections.

The problem with adherence to these principles inside a correctional institution is immediately apparent. There are no equal and mutually respectful relationships between correctional personnel and inmates. By definition, the inmate is a person of lesser status and lessened moral value and with fewer rights and privileges than administrators, officers and health providers. The essence of the relationship between inmates and correctional employees is hierarchical, which is the converse of equal.

To act within the ethic of their profession, health care providers must act counter to the prevailing ethic of the location. Between provider and patient, mutual trust and respect must exist in order for the relationship to work, i.e., to provide the support for diagnosis, care and treatment. The inmate must trust that the physician will act only in the inmate's best interest, will be his/her advocate and will place his/her health needs above all other considerations. Most providers enter correctional health care with these values, but they are challenged immediately and constantly by the overriding assumptions and norms of corrections.

Providers naturally identify with other non-inmates; all employees leave at the end of the day to lead lives defined by the general privileges and freedoms of society. In addition, distinctions of class and race may complicate the picture. Inmates tend to be poor and are overwhelmingly persons of color. Thus, classism and racism, acknowledged problems in American society, further complicate provider/inmate relationships. A goal of the correctional health professional must be to make the provider/inmate relationship as close to the doctor/patient relationship as possible. This requires on-going vigilance to recognize and counteract the natural shift to a correctional attitude and mores.

3. Informed Consent and the Right to Refuse Care: Informed Choice

Informed consent is the process of ensuring that the patient's values and preferences govern the care provided. The informed consent process requires that the doctor share with the patient sufficient information to permit the patient to choose among medical options. The physician must provide information on the diagnosis, the prognosis, the alternative available treatments, the risks and benefits of those treatments, and the possible outcomes if medical suggestions are refused. The patient must then apply personal history, private values, ability to withstand pain and suffering, and religious beliefs to reach a personally appropriate (even if idiosyncratic), voluntary, uncoerced,

informed and comfortable decision.

Once so stated, the problem is immediately apparent. Some scholars argue that prisons are places of such systematic deprivation and repression that voluntary behavior is precluded, although others have disagreed.[1] Prisons are the paradigm of the "total institution"[2] and work to destroy individual self-evaluation and independent behavior. Others argue that despite the nature of incarceration, inmates still can provide "good enough" consent[3] and that the alternative (i.e., consent by others) is even less appropriate. Structural supports may be required, however, to permit, buttress and facilitate the voluntariness of inmate choice.

Informed consent, as a process, has been defined as the ability to understand the information, measure the information against personal values and preferences, and communicate the ultimate decision.[4] Outside of prison, this process, although based in the moral agency and legal right of the patient, often involves discussion with and consideration of the interests of others. "What will it cost?" "What will be the impact on my family?" "How will others react?" These are all questions patients frequently ask as part of a personal calculus of decision-making. In prison, they are both harder to ask, as they are more abstract, and harder to answer.

Informed consent is a process and not a piece of paper. The requirement for obtaining informed consent or refusal is not satisfied by producing a document signed by the inmate. Informed consent describes the dialogue by which provider and patient share information, answer questions, hone the issues and decide on the steps to be followed in providing care. Especially in complicated medical situations, this may take time, many visits, and additional tests or data to reach a satisfactory conclusion. Time, respect, communication and trust are all central to the adequacy of this dialogue.

The rule outside of prisons is clear: with few exceptions,[5] adult persons who are capable of making health care decisions have the right to consent to or to refuse care, even if the result of that refusal is death. This rule is based on three common law conceptions: that any touching without consent and without legal justification is a battery; that every individual has a right to the possession and control of his/her own person free from interference except by legal authority; and that individuals possess a right of bodily integrity.[6] The last rule was stated most clearly in *Schloendorff v. Society of New York Hospitals* by Judge Cardozo who said "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." These rules, best expressed by philosophers in terms of autonomy, which justify and support permitting individuals to consent to and refuse care, were further buttressed by the Supreme Court in the *Cruzan* case. That opinion stated that "...the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."[7]

The law and the ethical analysis of informed consent and refusal inside of prisons are, not surprisingly, far more complicated. The legal rule appears to be that inmates have the right to consent to care, but do not have equally extensive rights to refuse care. One key case, *Commissioner of Correction v. Myers*, held that an inmate, who was attempting to refuse dialysis for his renal failure, could have his right to refuse care overridden, if his refusal and subsequent death could affect the administration of the prison. In this case, the court found that his refusal was not a genuine refusal of care, but rather an attempt to manipulate the system in order to obtain a transfer, and therefore, the court overruled his refusal of dialysis.

There is another reason to be leery of refusals of care in prisons; it is often difficult to distinguish between a refusal of care and a possible denial of care. In *White v. Napoleon*, there was an allegation that the behavior of a brutal and sadistic physician led inmates to refuse care.[8] These inmates stated that they did not truly want to suffer from their underlying medical conditions, but preferred that suffering to the deliberately painful and ineffective alternatives provided by the physician. When an inmate fails to appear for treatment, someone must determine whether s/he decided not to come because the symptoms abated,[9] or because of a conflicting program or perhaps, a family visit, or whether s/he was prevented from coming.

There may be practical ways of grappling with some of these ethical concerns. One way is to structure a system for inmate access to and refusal of ambulatory care that helps to ensure that any refusal is genuine and informed. Such refusals should be in writing and should occur in the health unit after the inmate has been counseled regarding the possible consequences of his/her refusal of care.[10] When the result of the refusal could be significantly health-imperiling or life-threatening, the DOC staff may wish to consider establishing an interdisciplinary committee composed of health professionals, cor-

rectional officials and clergy. This *ad hoc* group could meet with the inmate and discuss the refusal to ensure that it is informed and voluntary.

This discussion should not be construed to imply that every "no show" at sick call requires such extensive measures. As noted previously, the course of many illnesses is self-limiting. Written refusals should be required whenever there are potentially serious consequences of that refusal. Similarly, health staff should be required to follow-up "no shows" only when inmates' failure to appear may have an adverse effect on their health status.

4. Confidentiality

Confidentiality is central to the doctor/patient relationship. It is based upon a number of ethical principles (most prominently, respect for persons and their secrets) and a utilitarian principle of encouraging full disclosure. It also is based on the legal concept of "privileged relationships," which protect discussions between a husband and wife, priest and penitent, lawyer and client, and doctor and patient. This privilege is limited and means only that otherwise relevant information sometimes can be excluded in court. The privilege, however, reflects a societal policy that fostering open and honest communication in these relationships is so important that it justifies some sacrifices in the judicial process. Confidentiality generally is required of health personnel in their professional oaths, the observance of which is made mandatory by state licensing statutes.

Arrayed against these protections is a vast number of processes and procedures which, together, render the principle fragile and frayed: a hospital chart is a means of communicating and is open to all caregivers -- it supports the sharing of information, which permits continuity of care across shifts and among different professions; third party reimbursement opens charts generally to the scrutiny of the professionals; the computerization of medical information makes personal data easily accessible; gossip, which given human nature is widespread, opens secrets to public comment.

Despite this picture, the general ethic in medicine is that a patient's secrets uttered in confidence must be guarded by the physician or other health care provider. There are some exceptions to this rule and confidentiality is never an absolute; for example, a breach may be permitted for the good of the public (such as in mandatory reporting laws) or for the protection of a specifically endangered individual.[11] In general, however, the aura of confidentiality permeates health care interactions.

The principle of confidentiality should equally guide the provider/patient relationship within prisons; however, in prisons, the public health imperatives and the need to protect others from illicit drugs or weapons may conflict more often with the health care practitioner's duty of confidentiality. Outside of prisons, providers do not practice in an alien surrounding; they generally do not have conflicting loyalties. Inside they do, and that ongoing tension affects how the principle of confidentiality is employed in practice.

Maintaining confidential communication within prisons is a monumentally difficult task. Some breaches may be unavoidable; for example, medical information may be surmised from an inmate's pattern of movement or schedule of visits to the health unit. The rumor mill in prisons is busy and surprisingly accurate. In spite of this, every effort should be made to adhere to the principle of confidentiality. Sick call screening and triage should not be performed in dormitory units or within earshot of other inmates or correctional personnel. Health staff should not discuss one patient in front of another. Medical records themselves should be protected and should not be available to correctional staff. They should be stored in space that is protected from officer or inmate access.[12] When health records are transported by officers (e.g., during inter-unit transfers of inmates), the records should be placed in sealed envelopes or containers and delivered unopened to health staff.

Confidentiality is important not only to the privacy of an inmate, but also as an underpinning for the truth-telling necessary for an adequate history and physical assessment. Histories of drug and alcohol abuse as well as incidents related to trauma, or to sexual attack or behavior, are far more likely to be explained accurately to a provider if the inmate is sure of the privacy of the communication. If the provider acquires information that indicates an immediate danger to the inmate (e.g., suicidal intent) or an immediate danger to others (e.g., the possession of weapons), that information must be communicated to correctional authorities. Absent such identifiable dangers, inmates' secrets should be protected and guarded.

5. Biomedical Research in Correctional Settings

Research with human subjects in prisons and

jails has a long history of abuse in this and other countries.[13] In the past, prisoners often were used to test cosmetics or new vaccines or new chemotherapeutic agents without adequate prior informed consent. Even when there was ostensible consent, some argued that the systematic and profound deprivations of prison life vitiated the consent, because there was not a sufficient degree of voluntariness.[14]

In 1976, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research addressed the problem of research involving prisoners. Various perspectives were examined. One argued that prisoners gain a wide variety of benefits from participating in experiments including much greater financial reward than otherwise obtainable in prison; improved physical surroundings, which provide greater comfort and safety; and the relief from boredom. The proponents of research also argued that society as a whole gains from the increased scientific knowledge.[15]

Historically, prisoners involved in biomedical research were treated more humanely, given better living conditions and shielded from some of the boredom, danger and fear of prison life. Many inmates valued these benefits and sought to continue as subjects in research and drug protocols. Nonetheless, members of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research were concerned about the risks of research and the compromised ability of an inmate to weigh the risks and benefits, given the continuous emotional and material poverty of their surroundings.

These concerns led that national commission to recommend general restrictions on the conduct of research in prisons. Following these recommendations, Congress passed special federal regulations governing research on human subjects in general[16] and on prisoners in specific. The special section on prisoners[17] stated that the purpose of the regulations was "to provide additional safeguards...inasmuch as prisoners may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate in research."

The regulations identify four categories of permitted research:

a. Study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

b. Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

c. Research on conditions particularly affecting prisoners as a class (for example, vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere, and research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults) provided that the study may proceed only after the Secretary of the Department of Health and Human Services has consulted with appropriate experts, including experts in penology, medicine and ethics, and published notice in the Federal Register of his/her intent to approve such research;

d. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by an Institutional Review Board (IRB) to control groups which may not benefit from the research, the study may proceed only after the Secretary of the Department of Health and Human Services has consulted with appropriate experts, including experts in penology, medicine and ethics, and published notice in the Federal Register of his/her intent to approve this research.

Note, though, that research in these categories can proceed only when approved by a specially organized IRB with a prison advocate present, charged under the regulations with reviewing all research involving human subjects.

More recently, as the HIV epidemic has advanced and as more prisoners have become infected with the virus, the debates regarding the applicability of research have shifted to discussions about the availability of experimental treatments. Even in the past, there were prisoner advocates who argued that the federal regulations were preventing inmates from access to measurable benefits by restricting their participation in research.[18] Now, however, those assertions have particular relevance and poignancy.

Most treatments for the opportunistic infections that beset HIV-infected persons are carried out under the terms of research protocols. This is so because the virus and its treatments are so new that a moral posture toward the infection requires the maximum collection of data to support or disprove treatment hypotheses. Therefore, "protecting" inmates from research may mean effectively excluding them from "treatment." This irony of public policy has led some to argue that prisoners can and should be included in the later stages of research protocols (Phase II and Phase III) when there is no other access to care.[19] This same logic would apply also to prisoners with certain kinds of cancers where treatment generally is administered under research protocols.

Some states with a large percentage of HIV-infected prisoners may need to amend state law or regulations to permit research interventions in prisons. All institutions that choose to permit prisoners to participate in clinical trials (the last stages of drug testing) should establish guidelines and procedures to protect the process of consent.

6. Terminal Care and Advance Directives

The expansion of HIV infection in the drug-using community as well as the war on drugs have brought an increase in the number of prisoners who are HIV-infected or terminally ill with AIDS. In 1989, the New York state prison system reported approximately one inmate every other day was dying of an AIDS-related illness.[20] This was far in excess of any other state, but may foretell even more widespread infection in the years ahead.

Caring for the terminally ill requires compassion, skill in providing comfort and support, knowledge of pain management and the ability to help, and permitting the dying patient to experience the stages of death from denial to acceptance. It is difficult to provide for an acceptable quality of death in a prison where comforts are limited, providers skilled in dealing with the terminally ill may be scarce, and family and loved ones generally are excluded from intimate, continuous participation. Terminal care can be provided best by a hospice or hospice-like facility in the community. The needs of dying patients and the requirements of security are mutually exclusive. Compassionate release or medical furlough programs are best calculated to address the needs of dying inmates and their families.[21]

Even when this is not possible, every reasonable effort should be made to humanize the process of dying. There are a few prisons that have a thanatologist on staff to work with terminally ill inmates.[22] As the rate of HIV infection rises and the prison population ages, the services of a thanatologist and/or some program designed to meet the needs of terminal patients will become increasingly important.

Outside of prison, very ill or terminally ill patients, or healthy persons with strong and clear preferences increasingly execute advance directives regarding their health care choices for the future. These directives include living wills, which state specific preferences for care if the patient is no longer able to participate in health care decisions; and durable powers of attorney, which appoint a specific person to decide on health care plans if the patient is incapacitated and which, in addition, may or may not provide specific guidance regarding care choices. These documents become effective only when the patient is incapacitated and permit antecedent personal choice rather than the decisions of strangers (e.g., caregivers) to control care. The goal of advance directives generally is to limit care including ventilators, dialysis and resuscitation. They were developed by persons who saw the growth in medical technology and the potential for abuse if the existence of technology dictated its use.

The use of these instruments in prisons is problematic. If advance directives are approved for use, they must not be permitted to mask denials of care and they must be chosen voluntarily after adequate discussion. On the other hand, it would be unfair and unjust to deny prisoners this control over their health care at the end of life. Again, a multi-disciplinary committee of health providers from the prison and community as well as clergy and public officials may provide the perspective and oversight necessary to ensure fairness.

C. Bioethical Issues Unique to Correctional Settings

Health care professionals working in corrections are bound by the same code of ethics as their peers on the outside. The basic issues and principles of ethical conduct discussed in the prior section apply within a prison as much as in other settings. Nonetheless, it is more difficult to adhere to ethical principles within a correctional environment owing to two factors: the attitudes of some correctional personnel and the behavior of some inmates.

Correctional officers may feel that inmates are undeserving of good health care, particularly those who have committed heinous crimes or who are "troublemakers" within the institution. Correctional administrators -- especially if they control the health budget -- may believe that a required treatment is too costly and may put pressure on the health provider to alter his/her medical order or alternatively, may seek to delay carrying out that order. If the inmate is classified as an especially high security risk, the challenges to the health professional's judgment are likely to be even more adamant, especially if proper care requires the inmate to be transferred out of the prison.

On the other side are the inmates, some of whom may be extraordinarily demanding and manipulative. As noted in section B.1 of this chapter, there are a number of secondary gains that can accrue to an inmate by visiting the health services area beyond that of ostensibly seeking needed care. Inmates may press health professionals for services or medications that are not required. It is a rare prison physician (especially one new to corrections) who has not received repeated requests from inmates for medications for "nerves" or "sleeplessness" or "pain." Some inmates continue to test a provider until they determine that their efforts will not be automatically rewarded. Providers should recognize that this is not personal and needs to be responded to in a professional fashion.

As stated previously, the basic ethic of health care professionals is "do no harm," but what seems to be a simple precept can become complicated in a correctional setting. Health providers must ensure that their patients receive the care they need. At the same time, they must recognize that succumbing to inmate demands for unnecessary care may do as much harm as acquiescing to the improper requests of correctional administrators. Additionally, correctional health professionals must guard against "burn out," which usually emerges as a belief that many or most inmates are faking. That, too, can do harm by causing the health professional to ignore valid symptoms and thus, deny or delay needed treatment.

In this balancing of inmates' needs and wants against institutional demands, both inmates and correctional staff must be clear about the centrality of medical autonomy. Both must understand that health providers define permissible medical behaviors by their relationship to accepted medical goals. Medical autonomy means that the professional judgment of clinicians regarding their patients' needs cannot be overruled by non-medical personnel. It is a principle explicitly recognized in NCCHC's standards and those of the ACA. Its observance in correctional facilities is crucial owing to the special pressures in this environment described above; however, there is one caveat. Medical autonomy relates solely to clinical decisions regarding patients' care. Some correctional health professionals are quick to invoke the principle of medical autonomy whenever any of their decisions are overruled by the administration. This is comparable to some correctional staff who hide behind "security reasons" as an explanation for all of their decisions and actions. Both are inappropriate.

Administrative decisions such as when to schedule sick call should be arrived at jointly by the warden and the unit health authority. Clinicians may prefer to work 9 a.m. to 5 p.m., but the needs of the institution may dictate a different schedule. Health services is a support function within an institution, albeit a paramount one. Correctional health professionals would do well to accommodate security staff whenever they can do so without compromising their ethics or jeopardizing the health of their patients. In this way, the respect of correctional officials for legitimate areas of medical autonomy will be fostered.

To be effective, correctional health professionals should be neutral in non-medical matters. If they align themselves with security staff, they risk losing their effectiveness with their patients. If they are perceived as uncritical inmate advocates for other than health reasons, they risk losing the respect and cooperation of their correctional co-workers. Compounding this balancing act are the unique ethical dilemmas encountered in a correctional environment, some of which are described below.

Where useful and appropriate, national standards and other authorities are cited on particular issues. At times, though, they do not agree. Also, the listing is not exhaustive, but

illustrative so there are sure to be situations confronting correctional health professionals that are not addressed. In these instances, the solution for the individual practitioner lies in the general obligations inherent in the doctor/patient relationship. If a practitioner perceives that what s/he is being asked to do would compromise that relationship, then it should not be done.

1. Body Cavity Searches

Searching body orifices for contraband is done solely for custodial purposes. Nonetheless, correctional health personnel sometimes are asked to perform this function. The question of when such searches may be conducted is a legal issue whereas the question of who should conduct them is a professional issue that may impact on the provider/patient relationship. At first glance, it may seem appropriate that body cavity searches be conducted by health professionals, since they are more likely to be adept and to be considerate of the inmate's feelings; however, doing so compromises the health professional's neutral role with respect to correctional functions and may jeopardize subsequent health encounters with the inmate.

Both NCCHC's[23] and APHA's[24] standards explicitly recognize this ethical dilemma for correctional health professionals and both state that their participation in such searches is inappropriate. ACA's[25] standards allow health personnel as well as trained correctional staff to conduct body cavity searches, whereas JCAHO's standards are silent on this issue.

Certainly, there are occasions when body cavity searches may be justified either to protect that inmate or the welfare of other inmates or staff, especially if the concern is that a weapon has been secreted. For other types of contraband, correctional personnel should consider the option of placing the inmate in a dry-cell (i.e., one without regular toilet facilities). When it is necessary to conduct a cavity search, the AMA (1980) suggests that:

> *The* [non-medical] *persons conducting these searches should receive training from a physician or other qualified health care provider regarding how to probe body cavities so that neither injuries to the tissue nor infections from unsanitary conditions result;*
>
> *Searches of body orifices should not be performed with the use of instruments; and*
>
> *The search should be conducted in privacy by a person of the same sex as the inmate.*

One solution then is to use trained non-medical personnel to conduct body cavity searches. Another (although often less feasible) solution is to use community health providers who do not have a direct provider/patient relationship with inmates.

2. Collecting Forensic Information

There are a number of other circumstances in which correctional health professionals may be asked to collect information for forensic purposes including performing mental health evaluations of inmates for use in adversarial proceedings, conducting blood tests to determine drug and/or alcohol use or for DNA analysis and using radiological equipment to discover contraband. These situations pose special ethical dilemmas for correctional professionals since, unlike body cavity searches, they are medical procedures and require qualified health professionals to carry them out.

The consistent ethical approach would be for correctional health staff to refuse to participate in this type of evidence collection, which would require custody staff to seek these services in the community. Recognizing the impracticality of such a requirement in all circumstances, however, both APHA's and NCCHC's standards allow for some compromise. While APHA's standards[26] do not specify the exact situations when it is permissible, they do state that medical personnel may participate in evidence-gathering for court hearings if the permission of the inmate and his/her defense attorney are obtained. NCCHC's standards[27] prohibit correctional health staff from conducting psychological evaluations for use in adversarial proceedings, but would allow them to perform "court ordered laboratory tests or radiology procedures...with the consent of the inmate." Similarly, in cases of sexual assault, NCCHC's standards permit health professionals to gather forensic evidence if requested by the inmate-victim. Neither of these two sets of standards permit these activities to be carried out by correctional health staff without the inmate's consent and the exceptions to the general ethical rule of non-participation are very narrow. Neither ACA's[28] nor JCAHO's[29] standards address these issues.

Drawing blood specimens for DNA analysis warrants separate discussion. Like the blood alcohol test example above, this is done solely for forensic purposes but requires a medical person to draw the

blood. Unlike blood alcohol tests, though, which are drawn on specific inmates presumably when there is cause, many of the state laws mandating blood specimens for DNA analysis require them to be collected on large groups of inmates such as "all convicted sex offenders" or even "all convicted felons," which would be everybody in a prison. DNA analysis is a fairly recent development in forensics and, as such, is not specifically addressed in any of the sets of national standards; however, NCCHC has developed a policy statement that indicates that collection of blood for DNA analysis should not be performed by correctional health staff. It is recommended that a community health provider be used to draw the blood, or, if the volume warrants it, that someone be hired by the DOC specifically for this purpose.[30]

3. Witnessing Use of Force

Correctional officials may request that health personnel act as observers at planned use of force incidents, such as moving a recalcitrant inmate to a new cell or a different prison, in the belief that a neutral witness could refute any subsequent claims by the inmate that the force used was excessive. Inmates, too, may ask that a health professional be present in the hope that this will curtail extreme behavior. Again, however, this is a purely custodial function. In any event, in the midst of a conflict, it is unlikely that the presence of a health professional will affect the behavior of either the inmate or the correctional staff. Health staff should be readily available, though, to respond in case of injury.

Where the DOC's policies require a neutral witness in planned use of force incidents, it is recommended that a non-medical person be selected. Other staff who are not in a provider/patient relationship with inmates are not confronted with the same ethical conflict as health professionals. This recommendation is consistent with that of APHA's standards. The other three sets of national standards do not specifically address the role of health professionals in use of force incidents, although the ACA's 1990 manual has several standards designed to ensure that force is used only as a last resort.

4. Use of Restraints for Non-Medical Purposes

Correctional health personnel should not participate in either the decision to restrain someone or in the placement of such restraints when it is being done for non-medical reasons. NCCHC's standards[31] explicitly prohibit health care staff from participating in this activity, but go on to state that medical staff should monitor the health status of individuals placed in disciplinary restraints. If they observe conditions or practices that threaten an inmate's health, their concerns should be communicated to the prison administrator as soon as possible.

This is a troubling ethical dilemma for correctional health professionals. While it is clear that health staff should not participate in any form of punishment of inmates, some correctional staff would argue that restraints are not being used to discipline an inmate, but only to protect the inmate and others from violent behavior or to reduce the risk of escape. Indeed, the ACA's standards[32] prohibit the use of restraints as punishment. On the other side, some experts have argued that monitoring the health status of individuals in non-medical restraints is tantamount to participating in their punishment and should be condemned.[33] JCAHO's standards do not address this issue and neither the ACA's nor APHA's provide any guidance as to whether monitoring by medical staff of a restrained inmate's health status is appropriate, if the restraints are not for medical purposes.

This may be a situation where the underlying ethical principal is one of "doing the least harm." While some may argue that any involvement of health professionals in any aspect of "punishment" is inappropriate including monitoring their health, others would argue that health professionals have a moral responsibility to ensure the well-being of their patients in all situations and particularly when they are being disciplined, since that is the time that deterioration of health is most likely to occur. Until this issue is more settled, it is argued that NCCHC's position is the more reasonable approach, since it is likely to result in less harm to the inmate.

Before leaving this discussion, it should be clear that the ethical issue discussed above revolves around the use of non-medical restraints on inmates. When a patient is restrained for medical purposes, three of the sets of national standards (all except JCAHO's) require that there be written guidelines governing their use that specify the types of restraints that may be used; who may order them; and when, where, how and for how long they may be used.[34]

5. Disciplinary Segregation

Health staff should not be involved in any way in the decision to place an inmate in disciplinary

segregation.[35] Once there, the ethical issue of whether health staff should monitor the inmate's health status is similar to that regarding their role in monitoring the health status of inmates placed in non-medical restraints. The NCCHC's position is consistent in that its standards mandate daily evaluation of such individuals by a qualified health professional with appropriate documentation in the patient's medical record.[36] With respect to medical monitoring, neither the ACA's[37] standards nor APHA's[38] distinguishes between the different types of segregation and both require daily visits by health staff for all inmates whose movement is restricted.[39] JCAHO's standards do not address this issue.

If the ethical dilemma involved only monitoring inmates' health status, it could be resolved along the same lines as the prior discussion; namely, that it is less harmful to inmates for health professionals to monitor their health status while they are in disciplinary segregation than it would be to ignore them until they are released back to the general population. The NCCHC's standards add another factor, though, since they mandate that inmates be given a physical examination prior to placement in disciplinary segregation. This appears to be at odds with the APHA's statement that "...medical staff must refuse to participate in certifying that an inmate is free of illness and disease and therefore may be punished. The certification of wellness for punishment is a nonmedical function."[40]

In NCCHC's view, health professionals are not being asked to certify wellness so that an inmate may be punished, but rather, to determine if the inmate is not well. In the words of the standard's discussion, "...the purpose of the physical examination prior to placing an inmate in solitary confinement (disciplinary segregation) is to ensure that the inmate does not have any contra-indicating medical conditions that would require the postponement of this disciplinary measure."[41] Again, the ACA's standards and those of JCAHO do not cover this matter. Until a clearer consensus is arrived at by the standard-setting bodies or by professional health associations, correctional health authorities will have to determine for themselves and their staff which set of principles to follow on this issue.[42]

6. Other Punishment Modes

Occasionally, health staff may be asked to participate in other punishment activities and sometimes it may seem reasonable to do so. For example, health staff may want to "write up" or "ticket" inmates for institutional rule violations such as swearing at staff, particularly if they have been the recipient of such behavior. This should be avoided, except when the rule violation jeopardizes the safety or security of the prison and its occupants. Health professionals are not police and should not behave as such. Their education and training should have provided them with other ways to deal with abusive patients.

Similarly, some institutions list "malingering" or being a "no show" for sick call as disciplinary offenses. In the first case, health staff should be very cautious about a diagnosis of malingering, and even where they believe that an inmate does not have legitimate medical problems, that information should never be given to correctional staff as the basis for disciplining the inmate. Instead, if the medical judgment is that no further treatment is needed, it is up to the health professionals to manage the problem.

Health staff should work with correctional officials to ensure that inmates are not being punished for refusing treatment. The inmate has a right to be a "no show" for sick call. If the correctional concern is that the inmate was given a medical pass and instead went somewhere else, then he or she should be ticketed for "being out of place," not for being a medical "no show." This problem could be alleviated to a large extent if health units had a way for inmates to cancel their medical appointments.[43]

Another example of a punishment unique to corrections is ordering a "food loaf" for inmates who throw their food at correctional staff. These food loaves are supposedly nutritionally adequate, but their preparation and presentation often preclude human consumption. These are not "special diets" in the medical sense and health professionals should refrain from devising or prescribing them.

7. Hunger Strikes

None of the sets of national standards specifically addresses hunger strikes. They are a rare occurrence in corrections, but one for which health professionals often seek guidance when confronted with this problem. The ethical dilemma for correctional health staff posed by hunger strikers is not with those who may be mentally ill (since community standards allow caregivers to decide, in an emergency, what is in the best interests of patients who are not competent to decide for themselves), but

with those who are mentally competent. More often than not, inmates who are not mentally ill participate in hunger strikes for political and/or manipulative reasons. The well-publicized hunger strike of the Irish Republican Army's (IRA) members held in British prisons comes immediately to mind. In general, inmates who have the capacity to make health care decisions have a right to refuse care and treatment even when doing so is injurious to their health or threatens their life.[44] Presumably, that right may be extended to the refusal of nourishment required to sustain life. In the absence of specific case law or professional ethical guidelines, though, the brief discussion below should be viewed only as a departure point for further study and examination.

It is recommended that serious hunger strikes (e.g., those lasting more than two or three days) be supervised by an interdisciplinary committee of correctional and non-correctional personnel. A committee formed to scrutinize life-threatening refusals of care also might be appropriate for this task. If the committee agrees that the inmate has made a careful, considered, voluntary decision based on a principled position -- and not as a response to mental illness -- the inmate should be permitted to continue. At this point, the inmate should be moved to a medical setting. The task of the physician is then to keep the inmate apprised of his/her health status and the likely consequences of change or deterioration. The provider is the health consultant to the inmate. Force feeding the inmate clearly would violate his/her wishes and therefore, is precluded by adherence to concepts of patient autonomy discussed previously.

Up to this point, there is likely to be agreement among correctional health experts in terms of the proper management of hunger strikers. The dilemma occurs when the hunger strike continues to the point that the inmate becomes comatose. It is not clear whether an inmate who refuses sustenance should be allowed to die without interference from correctional or medical authorities. That was the end result of some of the IRA prisoners, but whether that is ethically appropriate is an open question. There is related case law in some states (e.g., *Commissioner of Correction v. Myers, State ex rel. White v. Narick*)[45] and several suicide cases that suggest the contrary. Until this issue is more settled, correctional and medical authorities would do well to seek a court order when confronted with a serious hunger-striking inmate.

8. Executions

Health personnel should not take part in any stage of the process of execution, which is the most clear and most direct violation of the principle "do no harm;" death is the ultimate harm. This is explicitly stated in the APHA's standards[46] and implied in those of NCCHC. In many states, a physician is required to certify death, and while this is not unethical in usual circumstances in the free world, it poses an ethical problem for correctional physicians -- particularly as to how they may be perceived by other inmate patients. Occasionally, there may be a botched execution such as a situation in Florida in 1990 when a problem occurred with the electric chair.[47] This places the physician in attendance in the awkward position of having to determine that the inmate is not dead yet, so that s/he may be "killed again." Additionally, some correctional physicians object to capital punishment on personal moral grounds. Thus, community physicians should be utilized to pronounce death subsequent to executions.

Despite this restriction, medical staff should care for the physical and psychological needs of death row inmates to prevent suffering. A very difficult issue is presented if the inmate is mentally ill, and especially if there is no suffering, and if treatment might remove the illness and make the inmate eligible for execution. This is a dilemma in the true sense, two conflicting senses of the "good" -- one to alleviate illness and the other to prevent death. NCCHC (1988) recommends in its policy statement that:

> *...the determination of whether an inmate is "competent for execution" should be made by an independent expert and not by any health care professional regularly in the employ of, or under contract to provide health care with, the correctional institution or system holding the inmate. This requirement does not diminish the responsibility of correctional health care personnel to treat any mental illness of death row inmates.*

D. Interfacing With Custody Staff

The prior section reviewed situations that limited the participation of health professionals in custodial functions. There are several other circumstances, though, when it is appropriate for health personnel to interface with custody staff.

Providing certain health information to classification committees, disciplinary hearing boards and institutional transfer groups are some examples discussed below.

1. Classification Committees

Most, if not all, DOCs have a statewide classification board that makes initial unit assignments and reviews transfer requests, as well as unit classification committees that determine housing, program and work assignments for inmates. In order for these groups to be fully effective, they must have some basic information about inmates' medical and mental health needs. For example, in most systems, not all prisons are equally equipped to address special health needs. An inmate with a chronic illness may require placement in a unit with an infirmary. Another may need to be assigned to a prison with programs and resources for the retarded or the handicapped or the aged and infirm. For still others, the geographic location of the prison is important if they require frequent transportation to a tertiary care facility. In the absence of some information about inmates' health status, statewide classification boards are not able to ensure that inmates' special medical needs will be met.

Similarly, unit classification committees should be aware of certain health conditions of inmates that may affect where they are housed or assigned to work. An inmate who is exhibiting signs of withdrawal or depression generally should not be single celled. One with epilepsy will require a lower bunk. An amputee may need to be placed on the ground floor. Other medical and mental conditions may restrict the inmates' assignment to particular jobs.

The issue for health professionals is how to provide important information to classification groups about inmates' health conditions without violating the inmates' right to confidentiality. The solution is relatively simple. A form can be devised that summarizes any medical restrictions regarding unit housing or job placement without revealing the inmate's precise condition or diagnosis. The Texas Department of Criminal Justice (TDCJ) uses such a form. A copy of TDCJ's "Health Summary for Classification" form is included as an example in Appendix A along with the health services' policy and procedure explaining its use.

There are other alternatives, of course. Some systems include health professionals as members of their classification groups. This is not recommended, though, for two reasons: first, the health professional risks revealing too much about an inmate's medical matters and second, it is not efficient to use a clinician's time in this fashion. Inmates' health needs are only one of the factors considered by classification groups and most of their time is spent reviewing offense and offender characteristics. In the past, some classification groups were given access to inmates' medical records during their deliberations. This should not be permitted. The goal should be to provide classification committees with only that health information required for them to make appropriate decisions regarding inmates' placement.

All three of the sets of national standards designed for corrections recognize the importance of input from health staff to classification committees' deliberations, although the ACA's focus is on mental as opposed to both medical and mental conditions.[48]

2. Institutional Transfers

As classification committees continuously juggle custody and medical classifications of inmates with prison work force requirements and available space, inter-unit transfers are inevitable. In most institutions, a list of the next day's transferees is provided to the health staff so that they can assemble the inmates' medical records. It is important that health staff review each record to ensure that the receiving unit has the requisite health resources to continue to meet the patient's needs. If not, a "medical hold" should be placed on that transfer and the matter brought immediately to the attention of the appropriate authorities. The importance of consultation between health and security staff prior to inter-unit transfers is recognized in NCCHC's standards[49] and those of the ACA.[50]

Further, while each DOC should have a policy that allows health staff to put a medical hold on any inter-unit transfer of an inmate, this is imperative for both inter- and intra-unit transfers of inmates who are currently medical or psychiatric inpatients. Decisions regarding admission to and discharge from inpatient facilities are the sole province of clinicians, a fact explicitly stated in NCCHC's essential standard governing skilled nursing and infirmary care.[51]

It should be clear that the inter-unit transfers referred to above are those for routine, non-medical reasons. Medical transfers are a separate issue. They are initiated by medical staff and the transportation is often by medical conveyance (e.g., ambulance, special van).

3. Disciplinary Hearings

In general, health staff should not participate in disciplinary hearings[52] and they should never be part of the punishment decisions. There are occasions, however, when information from health staff may be helpful in protecting the inmate from unjust discipline. For example, medication side effects may cause an inmate to behave in an abnormal fashion. Similarly, inmates who are mentally ill or retarded may not be responsible for their behavior or comprehend that what they did was wrong or against institutional rules. If the inmate's action is attributable to his/her medical condition, s/he should not be punished for it. Again, NCCHC's standards explicitly recognize the importance of consultation with health professionals on disciplinary matters for those inmates with significant medical or mental impairments.[53]

The term "consultation" may require further explanation. It is intended to mean only that for certain patients, the treating clinician be notified before disciplinary action is imposed. If there are any medical needs that cannot be met in a disciplinary segregation setting or any explanations of behavior that should be taken into account by the disciplinary committee, the clinician has an opportunity to voice them. Beyond that, the clinician should not be involved.

One practical way to notify correctional staff of any health concerns that may need to be considered in a disciplinary action against an inmate is to develop a form for this purpose. It can be a special form or part of another form containing information about inmate's medical needs that is routinely provided to correctional staff. For example, the Texas Department of Criminal Justice includes this information on its "Health Summary for Classification" form (see Appendix A). It is important to note that the information given to correctional staff is very limited.

4. Sharing Other Information

Beyond the information provided to disciplinary boards or classification committees, there are times when it is useful for line correctional staff to be given limited information about inmates' health conditions. For example, housing and work supervisors may be alerted to inmates with certain chronic conditions, mental instability, physical limitations, or those on medications with potential side effects. Such information should be provided only with the inmate's permission, though, since the sole purpose of doing so is for the inmate's protection. This information can help correctional staff to respond appropriately in the event of a medical crisis.[54]

Similarly, if an inmate has a communicable disease, correctional officers should be informed if any special precautions in handling the inmate are required. For example, if an inmate has active tuberculosis, correctional staff and others who interact with the inmate should be told what precautions they need to take against airborne infections. Again, it is not necessary or even appropriate to reveal the inmate's diagnosis. The intent is to provide only as much health information as is necessary for correctional staff to ensure the health and safety of that inmate, other inmates or themselves.

E. Conclusions

This chapter has explored some of the basic ethical imperatives that should guide health care providers regardless of the setting (e.g., informed consent, confidentiality, doctor/patient relationship). Here, the parallel is clear: if professional ethics would prohibit a particular action in a community setting, they prohibit it in a correctional setting as well. There are, however, certain ethical dilemmas that are unique to the correctional environment. In these instances, guidance on what constitutes ethical behavior can be sought from the two professional health associations that have drafted correctional health standards (i.e., APHA and NCCHC).[55] For the most part, the standards of NCCHC and APHA are consonant on ethical issues, but occasionally, they are not. Sometimes, the issue is too new (e.g., collecting blood for DNA analysis) or too controversial (e.g., whether or not to allow a hunger-striking inmate to die) to be included in the standards. Seemingly, what is still needed is the development of consensus within correctional medicine regarding acceptable ethical behavior of care providers in this unique environment.

ENDNOTES

1. See e.g., NCPHSBBR (1976).
2. See Goffman (1961).
3. See e.g., Dubler and Sidel (1989); Wishart and Dubler (1983).
4. See President's Commission (1983).
5. Pregnant women and the parents of dependent

children are exceptions to the rule, by case law, in some jurisdictions.

6. See e.g., *Cruzan v. Missouri.*

7. Do, however, see the discussion in Chapter III regarding *Washington v. Harper*, which held that an inmate's constitutionally protected liberty interest in refusing psychotropic medications could be limited to some degree by the state's interest in institutional safety.

8. The federal district court had agreed with the defendant's motion to dismiss the complaint for its failure to state a sufficient cause of action under the federal court rules. At this point, neither allegation of fact nor the merits of the case had been tested. The appellate court reversed and remanded saying the complaint, taken on its face, had sufficient allegations to require the action to proceed.

9. Refusals of care may reflect the self-limiting course of many illnesses. The disappearance of symptoms removes the necessity to seek care.

10. See Dubler (1986:109-110) and NCCHC (1987:48) for more information on informed consent and refusal. See ACA (1990:125) on informed consent.

11. See e.g., *Tarasoff v. The Regents of California.*

12. For more information on maintaining confidentiality of medical records, see ACA (1990:177), Dubler (1986:100) and NCCHC (1987:44-455).

13. See e.g., Dubler and Sidel (1989); Hammett and Dubler (1990).

14. See NCPHSBBR (1976).

15. See Branson (1976).

16. See Code of Federal Regulations (1981), Title 45, Section 46.301-06.

17. Subpart C of the Regulations on the Protection of Human Subjects, Code of Federal Regulations (1981), Title 45, Section 46.301-306.

18. See e.g., Dubler & Siedel (1989).

19. See Dubler and Sidel (1989).

20. See Griefinger (1990).

21. See also the discussion in Chapter VIII on addressing the needs of the terminally ill inmate.

22. For example, the Connecticut Correctional Institution in Somers has a thanatologist who works with the terminally ill. For a description of this program, see Gross (1990).

23. NCCHC (1987:6).

24. Dubler (1986:112-113).

25. ACA (1990:61).

26. Dubler (1986:113).

27. NCCHC (1987:6-7).

28. ACA (1990).

29. JCAHO (1990).

30. See NCCHC (1990).

31. See NCCHC (1987:39-40).

32. See ACA (1990:60).

33. See e.g., Costello and Jameson (1987).

34. See ACA (1990:122), Dubler (1986:41-42) and NCCHC (1987:39-40).

35. The ACA refers to it as "disciplinary detention," the NCCHC calls it "solitary confinement," and others may refer to it as "the hole" or "jail." Regardless of the exact term used elsewhere, "disciplinary segregation" as used here is intended to reflect the circumstance when an individual is locked down for punishment purposes and has certain privileges restricted. It is generally a short-term housing designation for disciplinary rule violations as opposed to administrative segregation or protective custody, which may be permanent housing assignments.

36. See NCCHC (1987:34).

37. See ACA (1990:81).

38. See Dubler (1986).

39. NCCHC's standards (1987:34) require health staff to visit "...all inmates who are segregated from the general population (whether for administrative or protective reasons)..." a minimum of three times per week. Daily evaluation is required only for inmates in disciplinary status.

40. Dubler (1986:113).

41. NCCHC (1987:34).

42. For accreditation purposes, NCCHC defines health evaluation of inmates in solitary confinement as an essential standard and thus, requires both pre-placement physicals and daily health evaluations. The ACA's requirement of daily visits by health staff of segregated inmates is designated as a nonmandatory standard.

43. See the discussion on sick call in Chapter VII and the sample form in Appendix F.

44. See the prior section in this chapter on the right to refuse care for a fuller discussion.

45. But see also *Zant v. Prevette* decided that same year that reached an opposite conclusion.

46. See Dubler (1986:114).

47. See the article in the Criminal Justice Newsletter (1990).

48. See ACA (1990:97 and 124); compare with Dubler (1986:8) and NCCHC (1987:5-6).

49. See NCCHC (1987:5-6).

50. See ACA (1990:122).
51. NCCHC (1987:36). See also the section on infirmary care in Chapter VII for a discussion of the use of inpatient beds for non-medical reasons.
52. An obvious exception occurs if the health professional is one of the parties involved, e.g., the victim of actual or threatened violence.
53. See NCCHC (1987:5-6).
54. See NCCHC (1987:5).
55. As stated previously, ACA's standards generally do not address ethical issues for health professionals and where they do (e.g., body cavity searches), they are at odds with the national standards of the two health bodies (i.e., APHA and NCCHC).

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CHAPTER V

THE ORGANIZATIONAL STRUCTURE OF PRISON HEALTH SERVICES

A. Introduction

One of the most important considerations impacting on the ability of a prison health care delivery system to attain its goals is the organizational structure under which it operates. Where the health services program is placed within the state department of corrections is often a reflection of the perceived importance of health care in relation to the department's total mission.

In the past, the typical organizational model in corrections was one where health professionals were responsible to the wardens of individual prisons. The wardens operated their institutions more or less autonomously and frequently, there was no consistency in the policies and procedures governing health services among the various prisons in a state system. Additionally, there was seldom any health care staff at the department's central office who was responsible for overseeing or coordinating health services in the separate prison units. At best, there was an individual at central office (usually with a correctional background) who was assigned the responsibility for "programs," which might include food service, social services, education and religious services in addition to medical, dental and mental health care. Further, even at the unit level, health services often were not organized under a single health authority. In particular, mental health was usually separate from the medical program.

There are a number of difficulties with such an organizational pattern. One of the more obvious is that the success of the health services program is dependent upon the good will of the wardens. The problem is not just that the wardens are non-medical persons and might not understand the need for increased positions, expensive equipment or outside specialty services. It is also that if the wardens are not progressive correctional administrators, the health staff may be too easily diverted from its primary objective of providing adequate care to inmates.

All health professionals working in correctional institutions must be aware of the potential for being co-opted by the prison administration.[1] Some health professionals are tempted (or in some cases coerced) to align themselves with correctional officials either by participating in non-medical matters (e.g. disciplinary actions against inmates)[2] or by siding with custody to the detriment of their patients' welfare (e.g. deciding that an inmate in segregation does not need an outside consultation after all, because of the security risk associated with transferring the patient to another facility). It is difficult enough on a day-to-day basis for institutional health professionals to withstand the pressures that may be placed upon them by custody officials even in those systems that have a health director in central office with line authority over health staff. In systems without a central health director -- where health professionals work directly for the wardens -- it is virtually impossible.

On the other side, a warden who may want to provide adequate health services to inmates is at the mercy of his/her health staff. Without a central office health director, the warden as a lay person has no way to judge the competency of the health staff or the adequacy of the delivery system. As noted by Brecher and Della Penna (1975):

> *While health care personnel at the institutional level are impotent, and know they are impotent, with respect to planning and carrying out improvements under this organizational pattern, they are free to let things slide with little or no fear of supervisory intervention.... Health care personnel in such an organizational structure are at the same time impotent to foster improvement and free to tolerate deterioration. This is a recipe for chaos. A change in this organizational structure is the most important initial step which any state can take toward improving correctional health care -- more important even than increasing appropriations* (at p. 45).

There are other problems as well with the traditional organizational model of correctional health services being placed under the control of individual wardens -- not the least of which is that it is not cost-effective. Clearly, cost savings can occur when certain items such as medications and supplies are ordered in bulk for the system as a whole, rather than in smaller amounts by individual institutions. Additionally, when health services are organized

under a central health authority, cost savings can be realized by sharing personnel and resources. These items will be discussed in more detail later in the chapter. For now, it is enough to note that the traditional organizational model of correctional health services does not serve anyone well -- not the warden who wants to provide good health care, not the health professional who wants to serve the patients' needs, not the director of the department of corrections who wants to avoid lawsuits, not the taxpayer who wants the most efficient utilization of public funds and not the inmate who is less likely to have his/her health needs adequately served under this model.

Since the traditional organizational model noted above is not recommended, what is the best organizational structure for correctional health systems? In order to answer this question, it may be instructive to look at the different organizational models being used in the various state prison systems and to examine the components of each.

B. Organizational Models

During the summer and fall of 1989, the National Commission on Correctional Health Care (NCCHC) undertook a telephone survey to determine the organizational structure of health services within the 50 state departments of correction. Probably the most striking result of this survey was the diversity of the models in use. Ten states (particularly the less populous ones)[3] still operated under the traditional model discussed above. There was no individual at central office whose full-time job was to oversee health services for the state prison system. Line supervision of health professionals occurred at the unit level by the warden. In most cases, medical, dental and mental health services were operated together at the individual prisons, but, in one,[4] mental health care was separate.

Another eight states[5] had a variation of this model. Here, there was at least one full-time person at central office who had responsibility for some aspects of health services statewide (e.g., administering the budget, developing policies and procedures), but line supervision of health professionals still rested with the wardens at individual institutions. In five of these states,[6] mental health care was not part of health services.

Another five states[7] utilized national for-profit firms to provide their health services in all their prisons. In four instances, the contract included medical, dental and mental health care, but in one (New Mexico), only medical and dental services were contracted out and the Department of Corrections (DOC) continued to operate its own mental health services. Three of these states[8] had at least one full-time DOC health employee in central office who was responsible for monitoring the health services contract, but the other two did not.

Nine states[9] had a mixed model in which health care was provided at some institutions by a contract firm and at others by the DOC. In six of these states, mental health was part of health services at specific institutions and in three,[10] it was not. Three of these states[11] had no full-time central office health director while two[12] had a small central office health staff who coordinated services, but did not have line authority over the health professionals in the institutions. In the other four states,[13] there was a strong central office health staff, with a health services director who not only was responsible for monitoring the performance of the contractor, but who also had line authority over health professionals working in the institutions operated by the DOC. In four of the nine states,[14] each had only one institution contracted out for health services, whereas the other five states had several.

There was another version of a mixed model used in the state of Arkansas. Here, medical services statewide were contracted out to a national for-profit firm, but dental and mental health care were not. There was a central office health staff with a statewide director who was responsible for overseeing the medical contract and had line authority over unit dental staff who were DOC employees. Mental health care also was provided by DOC employees, but under the direction of a separate mental health chief who was on a par organizationally with the statewide administrator of medical and dental care.

In the remaining seventeen states,[15] health services were operated solely by the DOC. Each of these states had at least one person in central office who served as the statewide health services director and who had line authority over the unit health professionals. Health services included mental health care in all but six[16] of these states.

Besides the diversity in organizational structure of correctional health services, there were other differences among the state systems. For example, the placement of health services in the DOCs' central office differed as did the position to which the statewide health services director (HSD) reported as well as the credentials of the individuals serving as

the HSD. Table V-1 summarizes the placement of health services within the DOCs' central offices. The states are divided into those that used contract firms and those that did not. For this table, a *division* is defined as the level immediately below the head of the DOC, a *section* is the second level below and a *group* is the third level below. Where there was a central office health staff, but without line supervision[17] of the unit health professionals, the term *consultant* is used for those systems run solely by the DOC and the term *contract monitoring only* is used for systems with contract care. It should be clear that while virtually every state had some professional services contracts with individuals or with laboratories, pharmacies etc., the term *contract care* as used here refers only to instances where health services for an entire DOC or for certain institutions within a DOC were operated by an outside (usually for-profit) firm.

In interpreting Table V-1, one *caveat* should be kept in mind. The placement of states under different columns was based on information provided by individuals interviewed during NCCHC's telephone survey. Interviewees were asked to describe the organizational structure of health services in their DOC and based on their responses, the author classified each system according to the categories defined in the preceding paragraph. While every attempt was made to ensure that there was shared understanding of the term *line supervision*, there is no guarantee that this was the case. Where misinterpretations (if any) occurred, it is likely that interviewees overstated their authority rather than understated it. In other words, a more detailed on-site study of the organizational structure of state correctional health services might reveal that fewer systems had line supervision than reported here.

Table V-1 shows that of the 35 state DOCs that managed their own health services, only seven of the central health offices had division status. Seven more had section status, three were at the group level and in eight states, the central health staff served only as consultants to unit health professionals. Ten states had no full-time central health staff. For the 15 states using contract firms in some capacity, five of those used DOC central health staff as contract monitors only and five had no full-time DOC health services director. The other five states were mixed models where central office health staff were responsible for monitoring the contract(s) for those institutions whose health services were operated by outside firms and where the statewide HSD had line authority over unit health professionals working in institutions whose health services were run by the DOC. Of this latter group, only Florida's central health office had division status whereas the other four had section status.

Table V-2 presents these data somewhat differently by indicating the position to which the full-time statewide health services director reported. Of the 35 states with full-time HSDs, only eight (23%) reported directly to the head of the DOC while 17 (49%) reported to the second level position, nine (26%) reported to the third level position and one HSD reported to the fourth level person from the top.

In Table V-3, the credentials of the individuals heading up correctional health services are presented. It should be noted that this table includes three part-time HSDs as well as two contract employees, so the total "N" is 40. In 16 states (40%), the HSD was a physician, although three of these individuals were only part-time in this capacity. Another 14 states (35%) utilized other clinicians as the HSD, usually nurses or psychologists. In the remaining 10 states (25%), the HSD was an administrator. Six of these individuals had degrees in administration, three had unrelated degrees and one person's degree was unknown.

Of the 27 full-time HSDs who were clinicians, all 14 of the non-physicians and six of the 13 MDs indicated that 100% of their time was spent on administrative rather than clinical tasks. The other seven physicians averaged 90% of their time in administrative work.

As noted in Table V-4, health services were integrated in 32 states (64%), whereas in 18 states (36%), mental health services were operated separately from medical and dental services. In five of the latter states, mental health care was provided by another state agency.

The states also differed regarding the number of health staff working in the central office. As shown in Table V-5, the number ranged from zero in ten states to 70 in Texas. Of those 40 states with central office health staff, two had part-time HSDs, nine averaged 1.3 staff, eight averaged 4.7, six states had eight central office health staff, eight states had an average of 14, three states averaged about 28 staff and Texas had the highest number at 70 (twice the number of the next highest state). The mean number of central office health staff for the 49 states reporting was 7.6.

Only six states had regional health staff: Florida with 27, Texas with 18, New York with 12, North Carolina with 6, South Carolina with 3 and Ohio

TABLE V-1
ORGANIZATIONAL STRUCTURE OF HEALTH SERVICES
IN THE CENTRAL OFFICE OF THE STATE DEPARTMENTS OF CORRECTIONS

	HEALTH SERVICES OPERATED SOLELY BY DEPARTMENT OF CORRECTIONS					CONTRACT FIRM USED					
						WHOLE STATES		MIXED MODELS*			
	Separate Division w/ Line Supervision	Separate Section w/ Line Supervision	Separate Group w/ Line Supervision	Consultant to Institutions (No Line Supervision)	No Full-Time Health Services Central Office Staff	Contract Monitoring Only	NO F/T DOC Monitor****	Separate Division/ Contract Monitoring	Separate Section/ Contract Monitoring	Contract Monitor Only	No F/T Health Service Central Office Staff
	CT HI*** ID MI NV NY*** TX	AK*** AZ CO MA MO*** OK OR***	CA NJ WI***	IN KY*** MN NC*** OH*** VT*** VA*** WA	LA MS MT*** NE*** NH ND RI SD UT WY	KS MD NM***	AL DE	FL	** AR*** GA*** IL SC	PA TN***	IA ME WV***
TOTALS	7	7	3	8	10	3	2	1	4	2	3
			(N = 35)					(N = 15)			

*In these states, either some institutions' health services are contracted out and some are run by the Department of Corrections or certain services (e.g., medical) are contracted out statewide, but other services (e.g., dental and mental health) are run by the Department of Corrections.

**Line supervision of dental staff only.

***Mental health care is not part of health services. It is provided by either a separate area of the Department of Corrections or an outside agency.

****These two states have central office staff employed by the contract firm, but there is no full-time DOC contract monitor.

TABLE V-2

FULL-TIME HEALTH SERVICES DIRECTOR OF THE DOC REPORTED TO:

	HEAD OF DOC (1ST LEVEL)	DEPUTY HEAD (2ND LEVEL)	DEPUTY'S ASST (3RD LEVEL)	4TH LEVEL PERSON	NOT APPLICABLE
	CT FL HI ID MI NV NY TX	AK AZ AR CO GA IL IN KS MA MO NM OH OK OR SC VT WA	CA KY MD MN NJ NC PA VA WI	TN	AL* DE* IA** LA ME MS MT** NE NH** ND RI*** SD UT WV WY
TOTALS (N = 50)	8	17	9	1	15

*Both of these states had central office contract employees, but neither had a full-time health service director employed by the Department of Corrections.

**In these three states, the physician health services director worked only part-time in that capacity.

***Rhode Island has a position for a statewide health services administrator, but it has been vacant for over two years.

TABLE V-3
TYPE OF PROFESSIONAL SERVING AS THE CORRECTIONAL HEALTH SERVICES DIRECTOR BY STATE

State	TYPE OF PROFESSIONAL: Physician	Other Clinician	Administrator	None	Employed by:
AL			unknown		Contract firm
AK			BA		DOC
AZ		DDS			DOC
AR		PA			DOC
CA	MD				DOC
CO		PhD**			DOC
CT	MD				DOC
DE		RN			Contract firm
FL	MD				DOC
GA		MA***			DOC
HI	MD				DOC
ID		PA			DOC
IL	MD				DOC
IN			MA****		DOC
IA	MD*				DOC
KS			MA****		DOC
KY		RPh			DOC
LA				X	not applicable
ME				X	not applicable
MD		RN			DOC
MA			MBA		DOC
MI	MD				DOC
MN			BA****		DOC
MS				X	not applicable
MO			BA		DOC
MT	MD*				DOC
NE				X	not applicable
NV	MD				DOC
NH	MD*				DOC
NJ		MA**			DOC
NM	MD				DOC
NY	MD				DOC
NC			MA****		DOC
ND				X	not applicable
OH	MD				DOC
OK	MD				DOC
OR		RN			DOC
PA			MA****		DOC
RI				X******	not applicable
SC		RN			DOC
SD				X	not applicable
TN	MD				DOC
TX	MD				DOC
UT				X	not applicable
VT		MA**			DOC
VA			MS*****		DOC
WA		RN			DOC
WV				X	not applicable
WI		RN			DOC
WY				X	not applicable
TOTALS (N = 50)	16 (3 P/T)	14 (1 - RPh) (1 - DDS) (2 - PA) (4 - PSYCH) (6 - RN)	10 (6 admin) (3 unrelated) (1 unknown)	10	(2 - contract firm) (10 - not applicable) (38 - DOC)

*Full-time employees who served only part-time as health services directors. The rest of their time was spent seeing patients.
**Psychology
***Counseling
****Health Administration
*****Economics
******Position vacant

TABLE V-4

NUMBER OF STATE DOCs WHERE THE HEALTH SERVICES PROGRAM INCLUDES MEDICAL, DENTAL AND MENTAL HEALTH CARE

	INCLUDES ALL THREE?		
	YES	NO	IF NO, EXPLAIN
AL	X		
AK		X	Mental health provided by separate branch of the DOC.
AZ	X		
AR		X	Mental health provided by separate branch of the DOC.
CA	X		
CO	X		
CT	X		
DE	X		
FL	X		
GA		X	Mental health provided by separate branch of the DOC.
HI		X	Mental health provided separately by the Department of Health.
ID	X		
IL	X		
IN	X		
IA	X		
KS	X		
KY		X	Mental health provided by separate branch of the DOC.
LA	X		
ME	X		
MD	X		
MA	X		
MI	X		
MN	X		
MS	X		
MO		X	Mental health provided by separate branch of the DOC.
MT		X	Mental health provided by separate branch of the DOC.
NE		X	Mental health provided by separate branch of the DOC.
NV	X		
NH	X		
NJ	X		
NM		X	Mental health provided by separate branch of the DOC.
NY		X	Mental health provided separately by Office of Mental Health.
NC		X	Mental health provided by separate branch of the DOC.
ND	X		
OH		X	Mental health provided separately by Dept. of Mental Health.
OK	X		
OR		X	Mental health provided separately by Dept. of Mental Health.
PA	X		
RI	X		
SC	X		
SD	X		
TN		X	Mental health usually provided by separate branch of the DOC.
TX	X		
UT	X		
VT		X	Mental health provided by separate branch of the DOC.
VA		X	Mental health provided by separate branch of the DOC.
WA	X		
WV		X	Mental health provided separately by the Department of Health.
WI		X	Mental health provided by separate branch of the DOC.
WY	X		
TOTALS	32	18	13 by separate branch of the DOC 5 by outside state health agencies

with 2. If the central and regional staff are combined (see Table V-6), the numbers change somewhat, but not dramatically. The range is from zero to 88 and the mean number of central and regional health staff for the 49 states reporting increases to 9.0. More information on staffing ratios is presented in Chapter VI.

The discussion above reflects the extensive diversity in the way in which health services were organized in the different state prison systems in 1989. The individual descriptions by state contained in Appendix B show even greater dissimilarity than when the data are grouped as in the tables. With so many options to choose from, what is the best organizational model for correctional health services? To answer this question, it is necessary to review the organizational structure components.

C. Organizational Structure Components

In creating a correctional health service or changing the structure of an existing one, there are several decisions that need to be made. Discussion of the various components of a model structure follows.

1. Need for a Statewide Health Services Director

Every state department of corrections -- no matter how small -- should have at least one individual who is responsible for health services systemwide. The health services director (HSD) should oversee the delivery systems at the unit level as well as develop statewide policies and procedures. S/he should approve the health services budget and serve as a resource person for the director of corrections at legislative budget hearings. Except perhaps for the very smallest states with an inmate population of 1000 or less, a full-time HSD is needed.

2. Reporting Structure for the Statewide HSD

The HSD should report directly to the head of the department of corrections. Health care is one of the most crucial and the most costly of the services provided to inmates. With the exception of overcrowding, probably more prisons are sued over inadequate health services than any other single condition of confinement.[18] A number of DOCs tend to place health services with other inmate programs such as food service, religious activities and library services, but this is not recommended. The importance of health services in the DOCs' total mission as well as the technical expertise required to make appropriate administrative decisions regarding personnel, service levels, equipment, supplies etc. argue for a separate division with direct access to the head of the DOC.

3. Type of Professional Serving as the Statewide HSD

The credentials of the individual serving as the HSD are as important as the level to which the position reports. Most of the states with HSDs were utilizing clinicians of one type or another to fill this position. This is not sufficient by itself. It is imperative that the statewide HSD have administrative skills, since this is an administrative not a clinical job. Clinical training usually does not include information on budgeting, finance, staffing patterns, matériel management or working with intragovernmental agencies, which are all skills needed by the HSD. An individual with a master's degree in health administration is much better equipped to make the correct administrative decisions than are clinicians without such training.

On the other hand, some people believe that the HSD position is so important that only a physician should fill it. According to Start (1988:17), "...only a physician has the power, ability and skill to obtain the necessary resources to operate an honorable system and to serve as an advocate for adequate and necessary services...." This is consistent with the APHA's standards which state that there should be a designated physician "...serving as the responsible and principal health authority...;"[19] but as Brecher and Della Penna (1975:46) note:

> *This pattern goes back to the days when hospitals and mental hospitals also had physicians in charge, and when it was commonly believed that only someone with an MD after his name could administer a health care institution. As physicians became busier and as health care administration became more complex, however, lay administrators have gradually taken over administrative responsibilities from physicians. A new profession of health care administrator has arisen, and has proved its usefulness. Sometimes, too, authority is lodged in a team -- a physician in charge of professional matters plus an administrator for other*

TABLE V-5

NUMBER OF CENTRAL OFFICE HEALTH STAFF BY STATE

	None	1 P/T	1-2	3-5	6-10	11-20	21-34	35+	All Contract	N/A**	TOTALS
	LA ME MS NE ND RI SD UT WV WY	IA - 0.5 MT - 0.1	ID - 1 IN - 1 KS - 1 KY - 1 MN - 1.5 NH - 1.5 NM - 2* PA - 2 VT - 1	AR - 3 AZ - 5 CO - 4.5 HI - 4 OH - 4 OR - 3 VA - 5 WA - 5	AK - 8 MO - 8 NV - 9 OK - 7 TN - 6 WI - 10	GA - 12 IL - 16 MD - 12 MA - 17 MI - 13 NJ - 18 NY - 12 SC - 12	CA - 24 FL - 34 NC - 25	TX - 70	AL - 5 DE - 7	CT	
TOTAL STATES	10	2	9	8	6	8	3	1	2	1	50
AVERAGE STAFF (x)		0.3	1.3	4.7	8	14	27.7	70	6	**	7.6***

* 1 CONTRACT/1 DOC
** DATA NOT AVAILABLE
*** BASED ON 49 STATES REPORTING.

TABLE V-6

NUMBER OF CENTRAL AND REGIONAL OFFICE HEALTH STAFF BY STATE

	None	1 P/T	1-2	3-5	6-10	11-20	21-34	35+	All Contract	N/A**	TOTALS
	LA ME MS NE ND RI SD UT WV WY	IA - 0.5 MT - 0.1	ID - 1 IN - 1 KS - 1 KY - 1 MN - 1.5 NH - 1.5 NM - 2* PA - 2 VT - 1	AR - 3 AZ - 5 CO - 4.5 HI - 4 OR - 3 VA - 5 WA - 5	AK - 8 MO - 8 NV - 9 OH - 6 OK - 7 TN - 6 WI - 10	GA - 12 IL - 16 MD - 12 MA - 17 MI - 13 NJ - 18 SC - 15	CA - 24 NC - 31 NY - 24	FL - 61 TX - 88	AL - 5 DE - 7	CT	
TOTAL STATES	10	2	9	7	7	7	3	2	2	1	50
AVERAGE STAFF (x)		0.3	1.3	4.2	6.75	14.7	26.3	74.5	6	**	9.0***

* 1 CONTRACT/1 DOC
** DATA NOT AVAILABLE
*** BASED ON 49 STATES REPORTING.

affairs. We recommend that state departments of correction take one of these routes and lodge overall responsibility for health care in the hands of a professional administrator or of a physician-administrator team.

The latter suggestion of a physician-administrator team is perhaps the best solution. A professional health administrator will need a physician clinical director to oversee professional matters and as noted previously, a physician serving as the HSD is likely to require a professional administrator to assist him or her in decision-making. It does not really matter whether the clinical director reports to the health services administrator or vice versa as long as one of them is the final administrative authority. NCCHC's standards[20] and the ACA's health standards[21] patterned after them allow either model. Where there is a physician who also is trained and experienced as an administrator, s/he could serve in both capacities. The physician's status in the community is an added advantage when approaching state legislatures for funding.

4. Areas Included Under Health Services

It is recommended that the health services program include medical, dental and mental health care under the same organizational umbrella. While each of these services may require a statewide clinical director, all three positions ultimately should report to the HSD. NCCHC's 1989 survey found that where health services were split in the state systems, it was always the case that mental health care was operated separately. Since inmates have minds and bodies that are combined in single entities, it is much more logical for the health services treating these minds and bodies to be combined. It is also more cost-effective, since some staff and some resources can be shared and ordering items such as medications, supplies and medical records can be completed more efficiently. Additionally, combining these services under a single health authority helps to improve the quality of care by ensuring that all providers have access to information regarding patients' allergies, current medications and health status.

For those states that use another state agency to provide mental health services, coordination of these services with the DOCs' health program is imperative. It is recommended that the DOCs' health services director (HSD) be responsible for coordinating mental health services and work with representatives of the outside agency to ensure that services are not duplicated and that pertinent information regarding patients is shared. Similarly, where one or more services are contracted out statewide and the DOC operates the remaining services, there still needs to be a single designated HSD who oversees the contract services and supervises the DOCs' services.

5. Health Services Operated by the DOC versus Privatization

During the past decade, much has been written about the privatization of correctional facilities,[22] but very little about the privatization of health services within those facilities[23]. This is understandable, since the legal questions raised by contracting out a traditionally governmental function (i.e., the operation of prisons) are much different from those raised by contracting out specific services. In the first instance, the legal issues include:

> *...whether government [can] delegate a function such as corrections to private industry, what the implications of such a delegation would be for liability if negligence or constitutional deprivation occurred, what the standards of performance should be, how performance should be monitored, and what would happen if there were breaches of contract or if a private correctional entity declared bankruptcy* (Sheldon Krantz in Robbins, 1988 at iii).

With respect to correctional health services, the basic legal issue is whether or not the care provided is adequate regardless of who provides it. As *West v. Atkins* made clear, a governmental agency is responsible for its health services whether they are supplied by government employees or by consultants under contract.

Additionally, while the issue of privately-run prisons may be new, the use of contracts *per se* in correctional health care is not. For years, departments of correction have contracted with pharmaceutical companies and medical supply houses for products. Also, DOCs have used contracts to obtain specific services such as laboratory analyses, radiological services, hospital care, emergency transportation and specialty care for their inmates. Further, virtually every system has at least some professional services contracts with individual providers.[24]

What is new is the concept of contracting out all health services at specific institutions or all institutions within a state to a private, for-profit firm. It was only in 1978 that the first of this type of contract occurred in a state correctional facility.[25] By 1985, three states were using all contract services, five more had some institutions under contract and in Arkansas' case, medical services only were contracted out statewide.[26] NCCHC's survey revealed that in 1989, there were five states using all contract services, nine with at least one institution under contract and one state (Arkansas) where medical services were contracted out statewide, but dental and mental health care were operated by the DOC (see Table V-1). While the use of contract firms to provide health care for correctional institutions has increased over time, by the fall of 1989, there were still only 119 (12%) of the 918 state prisons whose care was provided by an outside firm (see Table V-7). If institutions providing their own mental health and/or dental care are eliminated, the number of institutions whose total health services were contracted out by the fall of 1989 drops to 88 (9%).

To date, there has not been any controlled research that compares contract versus non-contract correctional health care with respect to quality, efficacy or cost, although opinions as to which is "better" abound. Proponents of for-profit contract firms claim that they can deliver quality care at a reduced cost to the state. Their detractors claim that state-operated health care can be equally cost-effective and that any cost-savings by contract firms are realized at the expense of a reduction in the extent and/or quality of care provided to inmates. In her article discussing contract health care, Alexander (1990:7) concludes:

> *Contract health care providers continue to merit close scrutiny. In comparison to a prison that offers no organized health care, contract providers tend to put basic protocols and organization in place. They generally use only licensed staff, and at least develop a paper plan for the delivery of health care. But too often, the existence of appropriate policies on paper may not translate into quality health care. As happens with traditional prison health care, too often the only criteria for filling physician positions will be that the candidate is licensed and still breathing. No matter how good a contract care system, or any other system, looks on paper, it must be evaluated in practice, particularly as it responds to medically difficult cases, before we can determine that it provides adequate health care.*

While there is no consensus on the merits of contract health care by for-profit firms, there are some recommendations that DOCs should follow if they decide to contract out their health services. The Prison and Jail Problems Committee of the American Bar Association (ABA) issued guidelines regarding privatization of corrections, which were adopted by the ABA's House of Delegates in February 1990. These guidelines covered the privatization of whole facilities, but also included contract health care. The ABA's guidelines relevant to health services are summarized below:[27]

a. There should be a clear statement that the contract is to be cost-effective and provide for proper care.

b. The contract term should be fair to both parties; three years seems to be a good balance.

c. The agreement should mandate that the contractor meet the percentage of NCCHC's standards required for accreditation.[28]

d. Contract employees should receive the same quality and quantity of training required for public employees. A private contractor also should comply with ACA's and NCCHC's standards on training, if they are more stringent than government requirements.

e. The state should appoint a contract monitor who has access to "any and all" information from the contractor "...that the monitor determines to be necessary to carry out the monitoring responsibilities" (p. 9). The monitor should issue reports on the con-tractor's performance at least annually. "Effective monitoring of a private contractor's performance under the contract is a *sine qua non* of any system that seeks to assure accountability" (p. 9).

TABLE V-7
NUMBER OF PRISONS WHOSE HEALTH SERVICES WERE CONTRACTED OUT IN 1989 BY STATE

States	Total # of Prisons*	Prisons Using Contractor for Some Health Services		Prisons Whose Total Health Services Were Contracted Out	
		#	%	#	%
AL	13	13	100	13	100
AK	13	0	0	0	0
AZ	15	0	0	0	0
AR	12	12	100	0	0
CA	19	0	0	0	0
CO	10	0	0	0	0
CT	20	0	0	0	0
DE	9	9	100	9	100
FL	35	1	2	1	2
GA	53	10	18	0	0
HI	10	0	0	0	0
ID	7	0	0	0	0
IL	20	14	70	14	70
IN	33	0	0	0	0
IA	8	1	12	1	12
KS	18	18	100	18	100
KY	10	0	0	0	0
LA	10	0	0	0	0
ME	8	1	12	1	12
MD	21	21	100	21	100
MA	22	0	0	0	0
MI	28	0	0	0	0
MN	9	0	0	0	0
MS	3	0	0	0	0
MO	16	0	0	0	0
MT	3	0	0	0	0
NE	9	0	0	0	0
NV	14	0	0	0	0
NH	5	0	0	0	0
NJ	15	0	0	0	0
NM	7	7	100	0	0
NY	60	0	0	0	0
NC	90	0	0	0	0
ND	2	0	0	0	0
OH	21	0	0	0	0
OK	23	0	0	0	0
OR	11	0	0	0	0
PA	14	5	35	5	35
RI	8	0	0	0	0
SC	32	5	15	5	15
SD	3	0	0	0	0
TN	16	1	6	0	0
TX	29	0	0	0	0
UT	6	0	0	0	0
VT	6	0	0	0	0
VA	55	0	0	0	0
WA	29	0	0	0	0
WV	10	1	10	0	0
WI	25	0	0	0	0
WY	3	0	0	0	0
TOTAL	918	119	12%	88	9%

*As reported by interviewees. It should be recognized that some systems included smaller institutions (e.g., honor camps, work release centers) in their totals and others did not.

f. The contractor "...should be required to assume all liability arising under the contract and should be prohibited from using immunity defenses..." (which are available to government agencies) to limit such liability.

g. "Private contractors should be required to provide adequate insurance coverage, specifically including insurance for civil rights claims" (p. 10).

h. In case it becomes necessary to terminate a contract on short notice, the state "...should have a comprehensive plan -- in advance of entering into a contract -- for assuming control of a facility immediately if necessary... including but not limited to the transfer of title to the contractor's files and records" (p. 10).

The last point deserves further comment. The contract should specify clearly that any written materials developed under the contract (such as policies and procedures, statistical and administrative reports) as well as certain files and the medical records themselves belong to the DOC and must be left with the DOC whenever the contract terminates. More than one correctional administrator has had the unhappy experience of finding the health services area virtually stripped of administrative documentation at the end of a contract.

Another important consideration is to note in the contract that the DOC (through its contract monitor, HSD or agency head) must approve all health services policies and procedures developed or used by the contractor as well as all forms for statistical and administrative reports and the medical records. Standardization of the medical record forms is particularly desirable and the DOC may wish to require that the contract firm use the DOC's forms rather than those developed by the firm's corporate office (especially in systems where only some institutions are to be contracted out). Similarly, the DOC may want to specify that the contract firm abide by the DOC's health services policy manual, or, if the contract firm's corporate policy manual is to be used, the DOC should require that this manual be tailored to reflect that state's needs.

Finally, it would be wise for the DOC to ensure that the contractor cannot prohibit health personnel from continuing to work at the facility when the contract terminates. Regardless of whether the DOC resumes providing its own health services at the termination of the agreement or (in the more likely case) another firm assumes the contract, the exclusion of the current health professionals would make it very difficult to restaff. It may be appropriate for the contract firm to exclude rehiring of its top supervisory personnel, but not other health staff.

In order to ensure that these recommendations are incorporated into the agreement between the state and the winning contract firm, they also should be a part of any request for proposal (RFP) or bid specifications. It goes without saying that such RFPs also should include very detailed descriptions of the types and amounts of services to be provided by the contract firm.

6. Line Authority Over Unit Health Personnel

In order to ensure that statewide policies and procedures are implemented at the prison units and that professional standards of care are followed, the HSD must have line authority over unit health staff. To place the HSD in the capacity of "consultant" to the prison health personnel is only a slight improvement over those systems that have no health services director. Without the authority to enforce compliance with statewide policies and practices and to fire health staff when necessary, the HSD (and other central office health staff as well) cannot be totally effective. Line authority also provides the HSD with greater flexibility in staffing. Certain positions can be shared by institutions and health staff can be reassigned on either a temporary or permanent basis as the system's needs dictate.

Some systems use a concept of "dual supervision" where unit health personnel are clinically and professionally responsible to the statewide HSD, but are responsible administratively to the head of the prison in which they work. Again, this is an improvement over the traditional model, but is less than ideal. The areas of authority are seldom so well-defined that conflicts do not develop between the wardens and the health services director. Additionally, the individual employee is placed in a potential bind, having to choose between two loyalties and at times, between conflicting orders. Under this system, more often than not it is the warden's directions that are followed, since the warden's supervision is immediate and daily and the statewide health services director's is remote and occasional.

While any model can work depending upon the personalities involved and the degree of leadership exercised at the top, it is recommended that the health services director have line authority over unit health staff. This model is simple and avoids the problems of conflicting loyalties of unit health staff and blurred areas of supervision. The HSD's authority should not be absolute, however. It is important to coordinate personnel decisions with the unit wardens, since their observations can be useful. Decisions regarding hiring, firing and disciplining unit health staff should be made only after input has been solicited from the warden, the chief of health services at the unit, and other relevant supervisory staff.

If the DOC uses a contract firm, the HSD ordinarily will not have line authority over contract health employees.[29] Nonetheless, the HSD can make recommendations to the chief contract administrator regarding the performance and suitability of specific contract personnel.

7. The Role of Central Office Health Staff

Because of differences in the size, organizational structure and complexity of state DOCs' health services, it is difficult to specify the exact number of positions that will be needed in central office. A better approach may be to discuss the types of activities that should be centralized and let each system determine the number of people it will take to perform these tasks in its own state. It has been stated already that every system -- no matter how small -- should have at least one full-time HSD and further, if there is to be only one health person in central office, both clinical and administrative skills are required. The reasons for these recommendations should become clearer after reviewing the activities listed below that should be performed by central health staff.

a. Fiscal Management[30]

One of the most important roles of the health services central office is to develop the budget for health services and to approve expenditures and contracts. It does not matter whether each prison unit's health services section develops its own budget (which is then consolidated in central office with other units' requests) or whether the central office health staff develops a budget for the system as a whole with input from unit staff. What is important is that the budget be approved by the HSD before being submitted to the director of the DOC and the legislature. Similarly, health services expenditures should be reviewed and approved by the HSD prior to payment.

The HSD also should approve all contracts for health providers, services and products used at the units. In most systems, it will be more cost-effective if the purchase of medical supplies and pharmaceuticals is centralized.

b. Standardization of Documentation[31]

In order to ensure consistency in care and administrative effectiveness, it is necessary that certain types of written materials be standardized. Paramount among these is a systemwide policy and procedure manual. It should specify the levels of care and types of treatment provided and cover administrative matters, personnel issues and medical-legal concerns as well. The basic elements of care and the policies under which staff operate should be the same for all prisons in the state system, although there may be some procedural differences from unit to unit. For example, the statewide sick call policy may indicate the level of staff conducting sick call and how the encounters are to be recorded, but the time and frequency of sick call may vary with the individual prisons' needs and size. In addition to the basic health services policy manual, larger systems will want to develop separate procedural manuals for certain services such as nursing, laboratory, radiology, physical therapy etc.

All forms used in the medical record also should be standardized throughout the system. This not only ensures that the same types of information are collected on each patient, but it also facilitates use of the record by staff -- both of which are important for continuity of care. In most state systems, inmates are transferred so often to other prisons that staff refer to it as "bus therapy." Transfers occur daily for security reasons, medical reasons and to regulate population overflow at particular prisons. If the same forms are used systemwide and all units follow the same chart order, it is much easier for health staff to review the records of transferred inmates and to ensure that their care is not interrupted. Further, it is much more cost-effective to print multiple copies of one set of forms than to print smaller quantities of different sets of forms developed by each unit.[32] It is recommended that states with mixed organizational models require their contract firms to use the same medical record forms as do the rest of their prisons.

Certain forms used for administrative and statistical purposes should be standardized as well. For unit data to be used appropriately for system planning and decision-making, they must be collected the same way and reported in the same format.

c. Staffing Issues[33]

Certain types of staffing activities are handled best on a centralized basis. The development of staffing ratios and decisions regarding shared positions and the placement of staff are more likely to be realistic if made by someone in central office who can view the system's needs as a whole. Additionally, the HSD can transfer staff and positions as the requirements of the units change.

Staff development is another area that often benefits from centralized planning. Continuing education is required for most health professionals both by licensing bodies and by standard-setting agencies. Centralization of this activity may include curricula development, conducting the actual training or simply coordinating the schedules and keeping the documentation for individual units. Similarly, most national standards mandate that correctional personnel receive health-related training on both a preservice and an ongoing basis. Central health staff should assist custody staff in this endeavor as well.

d. Quality Assurance/Risk Management[34]

Another important role of the HSD (or other central office health staff) is to oversee ongoing quality assurance activities. A plan should be developed that specifies the type of unit monitoring and evaluation that will occur, the criteria that will be used, the frequency of such monitoring and who will conduct it. Clinical supervision of unit health professionals and constant review of health care processes are imperative if quality of care is to be maintained and liability reduced.

In the larger prison systems, unit personnel should be required to conduct some quality assurance activities, while central staff concentrate on monitoring implementation of statewide policies, uniform documentation and special reviews. In the smaller systems, the statewide clinical director may undertake all quality assurance assessments. For those systems using contract firms, the HSD not only should monitor adherence to the terms of the agreement, but should conduct quality improvement studies as well.

Responding to inmate grievances on health matters is another activity that can be centralized. If the inmate is not satisfied with the answer provided at the unit level, it is important to have an individual outside the unit to whom s/he can appeal. The statewide HSD should be in the best position to determine the merits of inmates' complaints and to decide what remedies, if any, are needed.

e. Health Resources

There are a plethora of other decisions that need to be made on a systemwide basis including those on unit equipment needs, repair/renovation of clinical facilities and planning for new health services units. The HSD also must determine for each prison and the system as a whole which services it will be more cost-effective to provide in-house and which will be better to purchase from community providers. Some of these services (such as inpatient hospitalization, emergency medical transportation and dialysis) are very costly and require careful cost-benefit analysis of all available options.

Clearly, the increasing costs of providing correctional health care[35] coupled with the increasing level of sophistication required to cope with AIDS and an aging prison population[36] mandate the services of a statewide professional health administrator and a systemwide clinical director at a minimum for each DOC. As noted previously, the smaller states may wish to look for one individual who can serve in both capacities, if two full-time positions are not justified.

8. The Role of Regional Health Staff

Except for systems with the largest prison populations or those whose geographic spread or high number of units make it necessary to add another personnel layer, regional health staff are not required. Where used, the role of regional staff is generally to provide clinical supervision along professional lines. There are only a limited number of programs that may require a regional supervisor. These include dentistry, medicine and mental health. The number of unit staff in support programs (e.g., lab, medical records and physical therapy) is likely to be too small even in the largest systems to warrant a regional supervisor.

The primary role of regional staff is to serve as a clinical resource for unit staff and to monitor the quality of care provided by individuals in the program they supervise, although some admin-

istrative tasks (e.g., staffing decisions) may be included also. Within a regional office, it is not necessary for one individual to be designated as the "regional director", since regional staff should report along clinical lines to the chief of their program in central office.

In the largest systems, one other regional position may prove useful -- that of a regional administrator. The complexity of budget preparation, matériel management, reporting requirements etc. in a given system will determine the need for this position.

There is another type of regional office personnel that bears mentioning. Sometimes, the demand for specific services does not warrant full-time staff at the unit level and it may be more effective to provide services on a regional basis; for example, laboratory, pharmacy and radiology. The HSD should consider the potential cost benefits of this type of regional structure versus having each unit make arrangements for these services with local providers.

9. Organization of Health Services at the Unit Level

At the unit level, the most important consideration is to ensure that health services are organized under a single health authority. Both the wardens and the statewide HSD need someone that they can hold accountable for the operation and management of the prisons' health delivery systems. As with the statewide HSD position, the unit health authority (UHA) can be either a professional health administrator or a physician. If filled by the former, a clinical director should be appointed as well and if filled by the latter, an administrator usually will be required also. For professional supervision, all unit clinical positions should report to the clinical director, who either reports through the unit health administrator or directly to the statewide HSD (whether through regional staff or not). The sample organizational charts provided in Appendix C may help to clarify the recommended lines of authority.

D. Conclusions

This chapter explored a number of options for organizing health services within state departments of correction. In choosing among these options for various components of the organizational structure, some basic principles should be kept in mind. First, it is important to protect the autonomy of the health providers regarding clinical decisions; second, the organizational structure should enhance continuity of care; and third, the structure should facilitate quality assurance and monitoring activities.

While any organizational model can work -- depending upon the good will and rationality of the participants -- some models are less likely to work well than others. The simplest model and the one with the most likelihood of success is one where health services includes medical, mental health and dental care, and has division status within the department of corrections. The statewide HSD has line authority over unit health staff, controls the health services budget and reports directly to the head of the DOC. This professional model (for lack of a better term) reflects the principles noted above and avoids the problems of the traditional model described at the beginning of this chapter.

ENDNOTES

1. For a fuller treatment of co-optation and "burn-out" of health staff, see Chapter VI.
2. See Chapter IV for more information on the ethics of health staff participating in non-medical functions.
3. Louisiana, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Rhode Island, South Dakota, Utah and Wyoming.
4. Nebraska.
5. Indiana, Kentucky, Minnesota, North Carolina, Ohio, Vermont, Virginia and Washington.
6. Kentucky, North Carolina, Ohio, Vermont and Virginia.
7. Alabama, Delaware, Kansas, Maryland and New Mexico.
8. Kansas, Maryland and New Mexico.
9. Florida, Georgia, Illinois, Iowa, Maine, Pennsylvania, South Carolina, Tennessee and West Virginia.
10. Georgia, Tennessee and West Virginia.
11. Iowa, Maine and West Virginia.
12. Pennsylvania and Tennessee.
13. Florida, Georgia, Illinois and South Carolina.
14. Florida, Iowa, Maine and West Virginia.
15. Alaska, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Texas and Wisconsin.
16. Alaska, Hawaii, New York, Missouri, Oregon and Wisconsin.
17. The term *line supervision* is intended to reflect the situation where the central office health staff has

the authority to hire, fire and discipline unit health professionals.
18. See National Prison Project (1990).
19. Dubler (1986:105).
20. NCCHC (1987:2).
21. ACA (1990:109).
22. See especially Robbins (1988) and the extensive bibliography contained therein.
23. Three of the few articles found that discuss this issue are by Alexander (1990), Ingalls and Brewer (1988) and McCarthy (1982).
24. See the descriptions contained in Appendix B from the recent NCCHC survey. A 1985 survey found similar results (see "Prison health care," 1986).
25. According to McCarthy (1982:9), "In response to a federal court order, Delaware became in January 1978 the first state to move wholly to contract prison health care." Alabama followed in November 1979.
26. See "Prison health care" (1986).
27. See American Bar Association (1990) for the full text.
28. The American Bar Association also recommends that if the whole facility is contracted out to a private provider, it be required to meet the American Correctional Association's standards as well.
29. One notable exception is the degree of control exercised by the medical director of the Illinois Department of Corrections over contract employees. Each of the Illinois prisons where health services are contracted out has a state employee serving as the health services administrator. This individual is responsible for the operation of the health services unit including supervising contract personnel.
30. See Chapter XIII for more information on fiscal issues.
31. See Chapter XI for more information on the development of policy and procedure manuals and the standardization of data collection activities.
32. The impracticality of allowing each prison to develop its own forms was brought home to the author when she served as the assistant director of health services for the Texas Department of Corrections (TDC). Each of TDCs' 27 prisons had its own forms made up at the system's print shop. There were endless variations of sick call slips, administrative forms and medical record forms with the result that the print shop had hundreds of masters to catalog and store. The establishment of a Forms Committee to standardize and approve all forms used in the system reduced the number of masters to a manageable number, decreased the reproduction costs and earned the everlasting good will of the print shop manager.
33. See Chapter VI for more information on staffing issues.
34. See Chapter XII for a full discussion of quality assurance activities.
35. See the National Commission on Correctional Health Care's comparative cost survey reported in Chapter XIII.
36. See Chapter VIII.

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CHAPTER VI

STAFFING CONSIDERATIONS

The effectiveness of any correctional health care system is largely dependent on staffing considerations: Are there enough staff of the right types? Are they knowledgeable about their work environment? Are they clinically competent? Do they suffer from "burn-out"? Where can new staff be found? Much of an administrator's time is spent answering these and other questions related to staffing issues.

This chapter discusses some of the staffing concerns that require special consideration in a correctional environment. It is not intended to be a personnel manual, but it is hoped that the sections that follow will provide administrators with sufficient information to address staffing questions rationally. Topics include the development of staffing patterns, recruitment and retention of staff, the selection process, and in-service training and continuing education efforts.

A. Staffing Patterns

Deciding how many health staff of each type are needed is probably an administrator's most difficult task. Unlike the organizational structure or the service components of a correctional health system, there is no national "prison staffing model" that can be adapted to fit all institutions. All of the sets of national correctional health care standards have shied away from specifying exact staffing ratios -- and with good reason. The factors that influence the decision as to the number and types of health staff needed are many and varied.

By way of example, the results of an NCCHC survey may be instructive. As part of its 1989 study to determine the organizational structure of state correctional health services,[1] questions were included regarding the number of full-time equivalent (FTE) central office, regional and unit health personnel as well as the number of inmates in each state's system in 1989. As indicated in Table VI-1, there was tremendous variability in the staffing ratios among the 49 states reporting.

The ratio of central and regional office health staff to unit health personnel (see Table VI-1, column A) ranged from a low of 0:275 in Louisiana to a high of 1:10.6 in Alaska. The average ratio was about 1:40. The latter figure appears somewhat skewed, since there were ten states with no central or regional staff; however, if these ten states are excluded, the average central/regional office health staff to unit health personnel ratio is still 1:38. Similar variation was found in the ratio of unit health personnel to inmates served (see Table VI-1, column B). It ranged from a low of 1:100 in Wyoming to a high of 1:14.5 in Massachusetts. The mean ratio across the 49 states was 1:32.6.

In 18 of the 49 states reporting, mental health services were provided by a separate department or agency and thus, mental health staff were not included in their staffing totals. For comparative purposes, the states were separated into those with unified health services that included mental health staff and those that had separate mental health services and therefore, whose staffing totals excluded mental health staff. The ratio of central and regional staff to unit staff was comparable regardless of the organizational structure (see Tables VI-2, column A and VI-3, column A), but as expected, the ratio of unit health personnel to inmates was higher where mental health staff were included in the totals (compare Tables VI-2, column B and VI-3, column B).

The extent of variability in health staff to inmate ratios is seen best by comparing states of similar size. Five[2] of the states with unified health services were in the 12 to 13 thousand inmates size range as were two[3] of the states with separate mental health services. In the first group (see Table VI-2, column B), the staffing ratio ranged from about 1:29 in Arizona to 1:49 in Alabama. In the second group (see Table VI-3, column B), Virginia's health staff to inmate ratio was 1:27 and Missouri's was more than twice as low at 1:59.

It is impossible to conclude from the data presented above which staffing ratios are "better" or, indeed, whether any of them are adequate. A much more detailed staffing survey is needed that provides breakdowns by number and type of health staff and that ensures that all the states are counting and reporting their positions the same way. Even then, though, it would not be possible to determine which states had adequate staffing ratios and which did not, because there are so many factors that influence staffing patterns and that are difficult, if not impossible, to control for in a national survey.

TABLE VI-1
Comparison of 1989 Health Staffing Ratios by State

A. RATIO OF CENTRAL & REGIONAL OFFICE HEALTH STAFF TO UNIT HEALTH PERSONNEL

ST*	# OF CENTRAL AND REGIONAL HEALTH STAFF	# OF UNIT HEALTH PERSONNEL	RATIO
AL	5	245	1:49
AK**	8	85	1:10.6
AZ	5	429	1:85.8
AR**	3	85	1:28.3
CA	24	2000	1:83.3
CO	4.5	180	1:40
DE	7	93	1:13.3
FL	61	1535	1:25.2
GA**	12	430	1:35.8
HI**	4	80	1:20
ID	1	37	1:37
IL	16	534	1:33.4
IN	1	425	1:425
IA	0.5	50	1:100
KS	7	120	1:17.1
KY**	1	87	1:87
LA	0	275	0:275
ME	0	60	0:60
MD	12	304	1:25.3
MA	17	553	1:32.5
MI	13	1417	1:109
MN	1.5	45	1:30
MS	0	70	0:70
MO**	8	220	1:27.5
MT**	0.1	26	1:260
NE**	0	65	0:65
NV	9	120	1:13.3
NH	1.5	57	1:38
NJ	18	325	1:18.1
NM**	2	143	1:71.5
NY**	24	1500	1:62.5
NC**	31	496	1:16
ND	0	12	0:12
OH**	6	300	1:50
OK	7	200	1:28.6
OR**	3	115	1:38.3
PA	2	340	1:170
RI	0	50	0:50
SC	15	444	1:29.6
SD	0	14.6	0:14.6
TN**	6	320	1:53.3
TX	88	2700	1:30.7
UT	0	75	0:75
VT**	1	14	1:14
VA**	5	500	1:100
WA	5	300	1:60
WV**	0	45	0:45
WI**	10	120	1:12
WY	0	10	0:10
TOTALS	445.1	17,650.6	
N=49	x = 9.1	360.2	1:39.7

B. RATIO OF UNIT HEALTH PERSONNEL TO INMATES SERVED

ST*	# OF UNIT HEALTH PERSONNEL	# OF INMATES IN THE DOC	RATIO
AL	245	12,000	1:49
AK**	85	2,700	1:31.8
AZ	429	12,300	1:28.7
AR**	85	5,500	1:64.8
CA	2000	82,500	1:41.2
CO	180	6,000	1:33.3
DE	93	3,320	1:35.7
FL	1535	33,681	1:21.9
GA**	430	19,500	1:45.3
HI**	80	2,300	1:28.8
ID	37	1,750	1:47.3
IL	534	22,000	1:41
IN	425	13,000	1:30.6
IA	50	3,300	1:66
KS	120	6,000	1:50
KY**	87	6,000	1:69
LA	275	13,000	1:47.3
ME	60	1,400	1:23.3
MD	304	14,600	1:48
MA	553	8,000	1:14.5
MI	1417	26,000	1:18.3
MN	45	3,000	1:66.7
MS	70	6,500	1:92.9
MO**	220	13,000	1:59.1
MT**	26	1,400	1:53.8
NE**	65	2,200	1:33.8
NV	120	4,500	1:37.5
NH	57	1,160	1:20.4
NJ	325	19,000	1:58.5
NM**	143	2,800	1:19.6
NY**	1500	49,600	1:33.1
NC**	496	18,000	1:36.3
ND	12	550	1:45.8
OH**	300	27,500	1:91.7
OK	200	10,000	1:50
OR**	115	5,000	1:43.5
PA	340	19,000	1:55.9
RI	50	2,331	1:46.6
SC	444	13,000	1:29.3
SD	14.6	1,400	1:95.9
TN**	320	7,200	1:22.5
TX	2700	40,000	1:14.8
UT	75	2,300	1:30.7
VT**	14	712	1:50.9
VA**	500	13,600	1:27.2
WA	300	8,250	1:27.5
WV**	45	1,750	1:38.9
WI**	120	6,500	1:54.2
WY	10	1,000	1:100
TOTALS	17,650.6	576,104	
N=49	x = 360.2	11,757.2	1:32.6

*Data not available for Connecticut
**Does not include mental health staff

TABLE VI-2
Comparison of 1989 Health Staffing Ratios for States
With Unified Health Services

A. RATIO OF CENTRAL & REGIONAL OFFICE HEALTH STAFF TO UNIT HEALTH PERSONNEL (including Mental Health Staff)

ST	# OF CENTRAL REGIONAL HEALTH STAFF	# OF UNIT HEALTH PERSONNEL	RATIO
AL	5	245	1:49
AZ	5	429	1:85.8
CA	24	2000	1:83.3
CO	4.5	180	1:40
DE	7	93	1:13.3
FL	61	1535	1:25.2
ID	1	37	1:37
IL	16	534	1:33.4
IN	1	425	1:425
IA	0.5	50	1:100
KS	7	120	1:17.1
LA	0	275	0:275
ME	0	60	0:60
MD	12	304	1:25.3
MA	17	553	1:32.5
MI	13	1417	1:109
MN	1.5	45	1:30
MS	0	70	0:70
NV	9	120	1:13.3
NH	1.5	57	1:38
NJ	18	325	1:18.1
ND	0	12	0:12
OK	7	200	1:28.6
PA	2	340	1:170
RI	0	50	0:50
SC	15	444	1:29.6
SD	0	14.6	0:14.6
TX	88	2700	1:30.7
UT	0	75	0:75
WA	5	300	1:60
WY	0	10	0:10
Totals	321	13,019.6	
N=31	x = 10.4	420	1:40.6

B. RATIO OF UNIT HEALTH PERSONNEL TO INMATES SERVED (including Mental Health Staff)

ST	# OF UNIT HEALTH PERSONNEL	# OF INMATES IN THE DOC	RATIO
AL	245	12,000	1:49
AZ	429	12,300	1:28.7
CA	2000	82,500	1:41.2
CO	180	6,000	1:33.3
DE	93	3,320	1:35.7
FL	1535	33,681	1:21.9
ID	37	1,750	1:47.3
IL	534	22,000	1:41
IN	425	13,000	1:30.6
IA	50	3,300	1:66
KS	120	6,000	1:50
LA	275	13,000	1:47.3
ME	60	1,400	1:23.3
MD	304	14,600	1:48
MA	553	8,000	1:14.5
MI	1417	26,000	1:18.3
MN	45	3,000	1:66.7
MS	70	6,500	1:92.9
NV	120	4,500	1:37.5
NH	57	1,160	1:20.4
NJ	325	19,000	1:58.5
ND	12	550	1:45.8
OK	200	10,000	1:50
PA	340	19,000	1:55.9
RI	50	2,331	1:46.6
SC	444	13,000	1:29.3
SD	14.6	1,400	1:95.9
TX	2700	40,000	1:14.8
UT	75	2,300	1:30.7
WA	300	8,250	1:27.5
WY	10	1,000	1:100
Totals	13,019.6	390,842	
N=31	x = 420	12,607.8	1:30

TABLE VI-3
Comparison of 1989 Health Staffing Ratios for States
With Separate Mental Health Services

A. RATIO OF CENTRAL & REGIONAL OFFICE HEALTH STAFF TO UNIT HEALTH PERSONNEL (not including Mental Health Staff)

ST	# OF CENTRAL REGIONAL HEALTH STAFF	# OF UNIT HEALTH PERSONNEL	RATIO
AK	8	85	1:10.6
AR	3	85	1:28.3
GA	12	430	1:35.8
HI	4	80	1:20
KY	1	87	1:87
MO	8	220	1:27.5
MT	0.1	26	1:260
NE	0	65	0:65
NM	2	143	1:71.5
NY	24	1500	1:62.5
NC	31	496	1:16
OH	6	300	1:50
OR	3	115	1:38.3
TN	6	320	1:53.3
VT	1	14	1:14
VA	5	500	1:100
WV	0	45	0:45
WI	10	120	1:12
Totals	124.1	4,631	
N=18	x = 6.9	257.3	1:37.3

B. RATIO OF UNIT HEALTH PERSONNEL TO INMATES SERVED (not including Mental Health Staff)

ST	# OF UNIT HEALTH PERSONNEL	# OF INMATES IN THE DOC	RATIO
AK	85	2,700	1:31.8
AR	85	5,500	1:64.8
GA	430	19,500	1:45.3
HI	80	2,300	1:28.8
KY	87	6,000	1:69
MO	220	13,000	1:59.1
MT	26	1,400	1:53.8
NE	65	2,200	1:33.8
NM	143	2,800	1:19.6
NY	1500	49,600	1:33.1
NC	496	18,000	1:36.3
OH	300	27,500	1:91.7
OR	115	5,000	1:43.5
TN	320	7,200	1:22.5
VT	14	712	1:50.9
VA	500	13,600	1:27.2
WV	45	1,750	1:38.9
WI	120	6,500	1:54.2
Totals	4,631	185,262	
N=18	x = 257.3	10,292.3	1:40

The discussion below should help to clarify this point as well as illustrate why national staffing patterns for correctional health care have not been developed.

1. Factors Influencing Staffing Patterns

Many factors need to be considered in determining how many health staff of each type are needed to deliver the services that a correctional system wants to provide. Among these are the characteristics of the institution, the characteristics of the inmate population, the characteristics of the delivery system and other constraints.

a. Characteristics of the Institution

To begin with, size characteristics of the individual institutions and the system as a whole should be reviewed. It is not enough to base staffing decisions on average daily population figures alone. The total annual intake, the total annual population and average length of stay figures are important as well.

Two institutions with the same average daily population can have very different health staffing needs. Suppose, for example, that both institutions have an average daily population of 500 inmates, but Prison A is an intake unit and Prison B is a pre-release center. The annual intake at Prison A may be 10,000 with an average length of stay of two weeks for 99% of that population and two years for the 1% who are assigned there as workers. At Prison B, the annual intake may be 500 with a fixed length of stay of six months, yielding a total annual population of 1000. Obviously, the staffing patterns at these two institutions would differ dramatically as would the nature of services required.

Another characteristic of the institutions that affects health staffing is the number of inmates at each custody level at each facility. A prison holding a substantial number of maximum security inmates and/or housing a large segregated population will need a larger health staff than a similar sized institution with mostly minimum custody inmates. This is not necessarily a reflection of the greater health needs of individuals in higher custody classes, but, rather, may be attributable to security requirements. Often, maximum custody and/or segregated inmates may be moved only one at a time and usually must be escorted by more than one officer. Even though it is more efficient for the health staff to have a pool of inmates waiting in the clinic to be seen, security regulations may prevent it. Other security regulations can affect the health staffing needs as well. In some institutions, all basic services must be brought to the inmates who are segregated. For some health services (e.g., medication distribution), such decentralization means that more staff are needed, since the same service must be delivered in multiple sites at about the same time.

The size of an institution's segregated population can affect its health staffing needs in other ways. The three sets of national standards developed for corrections (i.e., ACA's, APHA's and NCCHC's) all require special monitoring of inmates in segregated status -- usually daily -- and NCCHC's requires a pre-placement exam as well.[4] These sets of standards further specify the need to document health rounds in segregation. Obviously, for a large segregated population, full-time health personnel may be required for this function alone.

b. Characteristics of the Inmate Population

The characteristics of the population to be served also must be factored into staffing decisions. For example, the number of inmates in various age groups may affect staffing needs. A prison holding primarily young offenders should require fewer health staff than one with an older population. Similarly, other special health needs of the population to be served will affect the numbers and types of health providers required.[5] A facility housing inmates with end-stage renal disease will need specially trained staff if dialysis is offered in-house. One holding physically handicapped inmates may need a physical therapist and a physiatrist at least part-time. Rates of communicable diseases such as hepatitis and tuberculosis as well as terminal illnesses including AIDS and cancer impact on health staffing requirements. The numbers and types of patients with special needs help determine staffing patterns at specific institutions.

The sex of the population served may be relevant as well. Obviously, the population's gender affects the type of health providers needed, since women require access to obstetrical and gynecological services, but many correctional health administrators also find that female offenders utilize health services more than their male counterparts. Some believe that female inmates are less healthy as a group than males and, thus, require more care. Others believe that females complain more and

utilize health services for secondary gains more than do male inmates. Neither position is substantiated by the literature. No published studies could be located comparing either the health status or health service utilization rates of male versus female offenders. If these data exist in specific states, such a study would be a useful contribution to the correctional health literature.

c. Characteristics of the Health Delivery System

The services delivered on-site at the facility obviously affect the numbers and types of health professionals required. Virtually all prisons (except, perhaps, small work or trusty camps) provide basic ambulatory medical care and, usually, routine dental services and outpatient mental health care as well. Many, though, do not provide inpatient services or may offer bed care only for medical and not psychiatric patients. Specialty services also are not offered at every institution nor are ancillary services such as laboratory, radiology or pharmacy.

Additionally, some prisons have special missions. A reception/diagnostic center may provide little in the way of ongoing services, since its patient base turns over rapidly. Another prison may house the system's inmates in need of dialysis, and thus, require staff skilled in its application. If the prison houses geriatric inmates or those with physical handicaps (mobility impaired, blind, hearing impaired etc.), special health services may be needed.

Each of the services offered at a given institution has implications for staffing, but knowing what services are provided is only part of the formula.

d. Other Considerations

There are other factors that influence the numbers and types of health staff needed beyond the primary determinants described above. For certain positions, it may be useful to determine the average time per patient required to perform specific tasks. At a reception center, for example, much of the staff's time is spent conducting repetitive activities. An LPN may take health histories and vital signs; an RN may spend the shift collecting samples for routine lab analysis; a PA or physician may perform physical examinations all day; and so forth for other services. Calculating the average time per patient per provider can help to determine the number of health staff of each type needed to fulfill a prison's health mission.

It is suggested, though, that health administrators not rely too heavily on a time and task analysis in the development of staffing patterns without consideration of other factors. To illustrate, suppose the health administrator at a reception center determined that it would take a physician or PA an average of ten minutes per patient to conduct a routine physical examination. On the basis of an eight-hour shift, the administrator calculates that 48 patients could be seen in a day (6 per hour x 8 hours = 48). The reception center takes in an average of 225 to 250 inmates per week (over 12,000 per year), so the administrator assumes that only one physician or PA is needed (48 patients per day x 5 days = 240 x 52 weeks = 12,480). The administrator is wrong and the facility is understaffed.

First of all, most individuals are not productive for the full eight hours of their shift. Even if a lunch break is separately accounted for, people still take time to visit with a colleague or to attend to personal needs. A realistic "fudge factor" should be included. Secondly, correctional institutions have built-in constraints that limit the productivity of clinical staff. For one thing, most prisons suspend other activities during counts and meals. This means that there will be a certain amount of "down time" for the clinical staff. For another, health staff generally must rely on custody to transport patients to and from the health area. If custody is short-staffed or uncooperative, the health services personnel may experience even more "down time." Further, some institutions require health staff themselves to be escorted, which can result in an even greater loss of productivity.

The architectural layout of the prison is another factor. If the health unit is located deep within the institution, it can take a half an hour or more to clear the various security checkpoints coming on and off shift. Additionally, a certain amount of a clinician's time is spent in non-clinical activities. There may be reports to write, meetings to attend and mandatory in-service training programs. Also, like other personnel, clinicians get sick and take time off for holidays and vacations.

Thus, it may be that with the "fudge factor," the physician or PA would see only five patients per hour and with the institutional time constraints, would have only six productive hours during the day. Instead of working 261 days per year (365 minus 104 weekend days) doing physical exams, s/he would be available only 220 days (assuming 41 days were spent on holiday, on vacation, out sick, in training or performing non-clinical functions). At this rate, a single physician or PA could perform only 6600

exams per year instead of the 12,480 projected originally. Two MD/PAs would be needed rather than one.

Another factor that can influence staffing ratios is the space allocated to the health unit. In the example noted above, there would be no point in having two clinicians on the same shift if there were only one exam room. Either physical exams would have to be performed on two shifts (which is not always feasible given other institutional activities) or a second exam room would have to be constructed. The availability of adequate space is one of the factors that should be considered in deciding which services will be performed on-site and which will be provided elsewhere. Sharing space is sometimes an option, but not if it means that one service will have to suspend its activities while the other performs its.[6] Such an arrangement only decreases the productivity of staff.

One final factor that can impact on staffing patterns is the existence of requirements external to the organization such as state licensing regulations, national standards or court orders. State licensing boards often help define the levels of staff required, since they dictate what tasks may be performed by what type of health professional. Generally, they do not specify the staffing ratios needed, although some states may require a specific level of supervision for physician extenders that affects the staffing pattern (e.g., a maximum of two PAs supervised by a single physician). National standards do not set staffing ratios either (except perhaps to specify minimum physician time),[7] but their requirements for performing certain services within specified time periods have obvious implications for staffing patterns.

Court orders are a different matter. They may dictate both staffing patterns and staffing ratios, which often have been established by consultant experts who may or may not be aware of all the various factors influencing staffing considerations in a given facility. Nonetheless, a paid consultant will develop staffing patterns and ratios, and in the absence of the facility's having a defensible staffing pattern, a court often will order the consultant's recommendations implemented.

The discussion above underscores both the complexity of developing adequate staffing patterns and the necessity for doing so. The question is, what is the best method?

2. Methods of Calculating Staffing Patterns

There are a variety of techniques used to calculate staffing ratios and patterns, ranging from guesswork to sophisticated formulas. Benton (1981) described some of the more common methods including task analysis, time and motion studies, productivity auditing, outcome analysis, process analysis and comparative analysis. *Task analysis* involves observing individuals at their work, breaking down each job into component parts and then assigning an average time to complete each task. The number of times each task must be done (i.e., the workload) is multiplied by the average time it takes to complete it. The result indicates the total time required, which then is converted into the number of staff needed for that task. Totaling up all of the time for all of the tasks for each position yields the staffing pattern.

Task analysis is a good strategy for those positions where the job consists of repeating the same activity over and over. But as Benton (1981:9-10) notes:

> *It has two basic flaws, however. First, it does not work well for more generalized tasks, a type which frequently occur in prisons...* [and second] *the methodology tends to underestimate the amount of staff required to do a job. It tends to assume that optimal levels of worker performance can be generalized, and this is not typically the case.*

A *time and motion study* represents another technique employed to determine staffing needs. It is a more sophisticated version of task analysis and subject to the same flaws. It has the additional disadvantage of being even more time-consuming and more costly to implement.

Another variation of task analysis discussed by Benton (1981:14) is *productivity auditing*. He states that "...the main difference between the productivity audit (PA) and the task analysis (TA) is that the TA asks 'How many employees are needed to get this job completed?', whereas the PA asks 'How can this work been done [*sic*] more efficiently?'." This technique may be the least applicable to corrections, since as noted in the prior section, many aspects of prison life take precedence over the efficiency of clinical staff.

Outcome analysis and *process analysis* are two other staffing pattern strategies discussed by

Benton[8]. The former operates on the assumption that the institution with the most problems needs the most staff, since it has the poorest outcome. Its sole advantage is that it is an intuitive strategy that requires the least effort on the part of the administrator employing it. Its disadvantages are that it tends to reward incompetence and inefficiency, and that it is the least able to determine what adequate staffing patterns should be.

Process analysis usually looks toward existing standards to develop staffing patterns and ratios. For example, NCCHC's standards or a court order might prescribe the amount of orientation and in-service training that health professionals need annually. This standard would be used to help determine how much time should be deducted annually for each person for training activities. Process analysis can be a useful technique for those areas where the standards are specific, but in many cases, the standards themselves are too general to provide much guidance.

A final technique discussed by Benton (1981:17) is *comparative analysis*. "[It] infers the adequacy of a staffing pattern by comparing it to a comparable situation in another institution. The effectiveness of this approach is dependent upon the appropriateness of the institution selected for comparison." This technique is not very useful in developing an initial staffing pattern for a prison of a given size, if there is no comparable institution. Some administrators try to use ambulatory care facilities in the community as a guide, but as noted previously, correctional institutions have built-in constraints and inefficiencies that make such comparisons questionable and usually result in understaffing. Others request staffing patterns from institutions of a similar size in neighboring states. Again, unless the administrator knows how those staffing patterns were developed and can be assured that all of the factors on which they were based are similar to those in his/her own state, this is not a useful approach. Once a rational staffing pattern has been developed, though, comparative analysis can be employed to approximate the staffing pattern for a prison of similar size and characteristics in the same state.

From the above discussion, it should be clear that no single technique will yield the best staffing pattern for a given institution or a correctional system as a whole. Combining elements of task analysis, process analysis and comparative analysis, though, can be an effective strategy. The question now is, how to begin?

3. Steps In Developing Staffing Patterns

In part 1 of this chapter section, various factors were described that affect staffing needs. They are not all equally important. The types of health services delivered at the facility is usually the primary determinate of the types of staff needed. Assuming that the decision as to the types and levels of care to be provided on-site has been made rationally -- that is, based on the population's needs balanced against the cost of and distance to community resources -- then it is appropriate to allow the services delivered to dictate the types of health professionals required.

The first step in developing health staffing patterns for a correctional system is to determine the health mission of each prison. It may be useful to devise a checklist that summarizes the services provided at each facility, such as the sample "Health Delivery System Profile" form shown in Exhibit VI-A. Its purpose is simply to identify all the services provided on-site at any prison in the system to ensure that no program with staffing implications is omitted. The checklist should be completed for each institution in the system. The *# to be served daily* column can be left blank until more information is obtained.

The second step is to gather the necessary statistics and other information about each prison and its population. The sample "Prison Profile" form shown in Exhibit VI-B can be used as a guide. The categories are only suggestive, so the actual length of stay breakdowns, custody class, housing status and age breakdowns should reflect the terminology and groupings used in a given state. The information from this profile is used to complete the *# to be served daily* column on the Health Delivery System Profile form.

For example, if the prison has an intake function, then the number to be served daily is derived from the *total annual intake* figure on the Prison Profile form divided by the number of days per year the service is offered. An estimated number to be served daily at sick call can be obtained from prior year figures on sick call visits, if such statistics were kept. If not, it can be estimated by looking at average daily population (ADP) figures and length of stay breakdowns. The latter figure is important if most of the population is not staying at the prison a full year. To illustrate, a reception center with an ADP of 1,000 may have only 100 inmates (e.g., assigned workers) staying the full year. Sick call services should be planned against a base of 100 not 1,000, since most of the population does not stay at

the prison long enough to utilize sick call regularly. On the other hand, medication distribution is provided daily regardless of length of stay, so it should be projected using the ADP as a base. Similar logic is used to estimate the daily patient load for each service offered. Obviously, this step is much easier to complete if patient utilization figures have been kept regularly.

The next step is to break each service down into specific tasks, decide what level of health professional is needed to complete each task, and develop some time estimates. This step combines elements of process analysis and task analysis. Looking at state licensing regulations, national standards and court orders (i.e., process analysis) may help define the specific tasks that need to be completed, identify any time elements that should be considered (e.g., "sick call must be held five days per week") and determine the level of staff permitted to accomplish each task. Then, task analysis can be performed to determine the average time per patient it takes to complete each task. As noted previously, task analysis works well only for those activities that are repetitive and can be quantified against a patient base. A different way of estimating staffing is needed for positions of a more general nature such as "health administrator." Some definition of terms may be useful.

Benton (1981:29) says a *post* is a job "...defined by its location, time, and duties, but which may be filled interchangeably by a number of [people]" whereas a *position* "...refers to a job which is held by a specific person." Job titles such as *health administrator, quality assurance coordinator* or *in-service training director* are usually positions, whereas titles such as *infirmary nurse, sick call nurse* or *segregation nurse* refer to posts. Posts lend themselves to task analysis; positions usually do not.

Positions generally are assigned based on the size of the institution combined with practical considerations. For example, it may be that one prison with an ADP of 500 and one with an ADP of 1000 each has a full-time health administrator. The latter may be the optimum workload for an administrator, so it would seem that the smaller prison would need only a half-time administrator. It may be, however, that no other nearby prison also needs a half-time administrator or that it is not possible to hire a person part-time. Therefore, practical considerations dictate that both prisons receive a full-time person.

Performing task analysis can be very time-consuming, since it involves observing individuals at their work, taking repeated measures of the time involved in completing each task, and computing an average. Accordingly, it is suggested that tasks not be disaggregated too finely. In other words, it is sufficient to define what happens in a single patient encounter with a provider as a "task" without breaking it down further into the separate amounts of time it takes to review the record, provide the treatment and document the encounter. Additionally, some tasks may require more than one level of staff to perform. For example, both a physician and a nurse or a physician and a clerk may be present for the same sick call encounter.

Another consideration is to identify which tasks are performed by which shift and how often. For example, sick call may be held only on the day shift, Monday through Friday, but outpatient medication distribution occurs twice on the day shift and once on the evening shift, seven days a week, and nursing rounds of infirmary patients are required on all three shifts, seven days per week.

Even if task analysis is not actually conducted, it is useful to try to develop some estimates of the time per patient spent by different health professionals in various activities. One alternative is to survey various types and levels of health professionals at different institutions and ask them to account for how they spend their time per day and how long they spend on average in each type of patient encounter or activity.

Once time estimates have been developed for specific tasks, the next step is to assemble the data by the level of health professional required. In other words, all of the tasks performed by LPNs are grouped, all of those by RNs are grouped etc. This is done in preparation for determining shift patterns and coverage requirements.

It is likely that any task analysis or job survey has been done on the basis of posts. If not, this is the time to review all of the tasks and determine which tasks should be assigned to which shift and which can be accomplished by what post. Certain activities will occur only on a single shift. Others must be repeated on more than one shift. The tasks should be laid out by type of health professional by shift, along with time estimates for the completion of each task. The latter are added to arrive at total workload hours by type of health professional per shift.

Now the decision as to coverage comes into play. For the most part, positions are filled on a single shift only, five days per week, and it is not necessary to include a coverage factor for multiple shifts, week-

EXHIBIT VI-A
SAMPLE
HEALTH DELIVERY SYSTEM PROFILE

Institution Name _____ Date _____

PROGRAM	SERVICES OFFERED Yes	No	# TO BE SERVED DAILY
I. MEDICAL			
A. Basic Ambulatory Care			
1. Intake			
2. Sick Call			
3. Medication Distribution			
4. Chronic Disease Clinics (list each)			
a. diabetes			
b. hypertension			
c. etc.			
5. Special Programs (list each)			
a. physical therapy			
b. respiratory therapy			
c. etc.			
B. Specialty Care (list each service offered on-site)			
1. Dermatology			
2. OB/GYN			
3. etc.			
C. Infirmary Care (list type, level and # of beds)			
1. General Medical			
a. skilled nursing (# beds __)			
b. extended care (# beds __)			
2. Special (e.g., geriatric, hospice for terminally ill) (# beds __)			
D. Ancillary Services			
1. Laboratory			
2. Radiology			
3. Pharmacy			
4. Dietetics			
5. Other (list)			
II. MENTAL HEALTH			
A. Basic Care			
1. Intake			
2. Post-Admission Evaluation			
3. Counseling			
a. individual			
b. group			

Exhibit VI-A (cont'd)

PROGRAM	SERVICES OFFERED Yes	No	# TO BE SERVED DAILY

II. MENTAL HEALTH (cont'd)
- 4. Other Therapies (list each)
  - a. recreational
  - b. occupational
  - c. etc.
- 5. Special Programs
  - a. mentally retarded
  - b. crisis intervention
  - c. suicide prevention

B. Psychiatric Consultation

C. Infirmary Care
- 1. Acute (# beds __)
- 2. Extended (# beds __)

III. DENTAL

A. Basic Care
- 1. Intake
- 2. Repair & Maintenance (e.g., fillings)
- 3. Prevention
- 4. Prophylaxis
- 5. Protheses
- 6. X-ray
- 7. Lab

B. Specialty Care
- 1. Oral Surgery
- 2. Periodontal Care
- 3. Other (list)

IV. OTHER
- A. General Administration
- B. Quality Assurance
- C. Health Education
- D. In-service Training
- E. Housekeeping
- F. Medical Records

V. CUSTODY
- A. Basic Security
- B. Escort (In-house)
  - 1. Patients
  - 2. Staff
- C. Transport (Outside)

EXHIBIT VI-B
SAMPLE
PRISON PROFILE

Institution Name _____ Date _____

A. General Statistics (use most recent data or projections)

1. Total annual intake _____
2. Average daily population (ADP) _____
3. Total annual population _____
4. Average length of stay (LOS) _____
5. LOS breakdowns (# or %) _____

< 1 month	_____	1-2 years	_____
1-3 months	_____	3-5 years	_____
4-6 months	_____	6-10 years	_____
7-12 months	_____	> 10 years	_____

6. Custody Class (# or %)

Minimum	_____	Close	_____
Medium	_____	Maximum	_____

7. Housing Status (# or %)
   - ___ general population
   - ___ special medical/mental health housing
   - ___ protective custody
   - ___ administrative segregation
   - ___ disciplinary segregation
   - ___ other (specify _____)

B. Population Characteristics

1. Sex (# or %) Male _____ Female _____

2. Age (# or %)

___	< 18	___	41-60
___	18-25	___	61-75
___	26-40	___	> 75

C. Special Considerations

1. Identify any security regulations that impact on the delivery of health services (e.g., "administrative segregation inmates may be moved only one at a time" or "disciplinary segregation inmates may be moved only one at a time and require two officers").

_____
_____
_____

2. Identify all decentralized health services (i.e., those provided in inmate housing areas rather than the health services unit). For example, "all medication distribution done cellside" or "medication distribution done cellside for all segregated inmates" etc.

_____
_____
_____

ends or time off. If a health administrator is absent (whether sick, on vacation, etc), it is assumed that s/he will catch up on the workload when s/he returns. For certain posts, though (e.g., infirmary nurse), it is crucial that there be coverage seven days a week, 24 hours per day. Therefore, regular time off for people filling these posts must be accounted for to ensure continuous coverage.

Coverage factors should be calculated for each state system. The DOC's personnel policies generally specify authorized days off for sick leave, vacation, holidays etc. Added to these is the average time spent per employee in training, meetings etc. The total days off is subtracted from the annual number of work days which is usually 261 (i.e., 365 days minus two days off per week times 52 weeks = 365 - 104 = 261). This results in a coverage factor per employee, which is then used to calculate coverage for a post for a single shift, seven days per week and for a post requiring continuous coverage 24 hours per day, seven days per week. Benton (1981) has developed a useful chart to calculate coverage factors, which is reproduced in Appendix D.

The final step is to add up the number of staff of each type required for each post (including the coverage factor) and each position at each institution. This yields the total health staffing complement needed at each prison. The staffing requirements for each prison then can be reviewed to see if any positions reasonably can be shared by neighboring institutions.

As noted at the outset, developing rational staffing patterns for prison health care is a technical and time-consuming activity. They must be created separately for each prison in the system in order to ensure that inmates' health needs are met. If a correctional system has prisons that are comparable in size and custody class, and if the health delivery systems are comparable in types of services offered, the job can be reduced somewhat. Staffing patterns can be developed for prototypes and then adjusted and refined based on special considerations. Employing comparative analysis can be useful if, in fact, the prisons are similar on relevant variables.

Given the onerous task of developing staffing patterns *de novo* at different institutions, it is no wonder that individuals charged with this responsibility seek short cuts or that lawyers involved in prison litigation look for easy answers to what constitutes adequate health staffing. There is no request received more often at the National Commission on Correctional Health Care (NCCHC) than that for model health staffing patterns. The temptation to create them has been weighed against the very real dangers of doing so. It is recognized that whatever staffing models might be developed would be applicable only to facilities that shared all of the assumptions on which such staffing was based. No matter how carefully such assumptions were laid out, there always would be individuals who would ignore them and adopt a staffing pattern wholesale, simply because it was easier than developing one themselves.

The potential danger of a national organization developing sample staffing patterns for different sized prisons is twofold: First, they might not reflect the most efficient utilization of health staff at a given institution and second, they might not be effective. In the former case, overstaffing would result in unnecessary costs to the taxpayers and in the latter, understaffing would result in inmates' health needs going unmet. Neither is a desirable outcome. The very complexity of the task and the numerous factors that affect the result are what argue for creating health staffing patterns on a case-by-case basis.

B. Recruitment and Retention Strategies

It is much easier now than in the past to attract and retain qualified health professionals to work in correctional institutions. For one thing, most prison systems have learned that they must be competitive with the "free world" in terms of the salaries, benefits and work environments they offer health professionals. For another, the labor pool of many types of clinicians has expanded. The increasing respectability of correctional medicine coupled with the growing disillusionment of some practitioners with traditional practice settings has resulted in a greater willingness on their part to consider correctional health care as a career.

It is difficult to state with any certainty what makes a particular job attractive to one person and unattractive to another. There are some commonalities, though, that most people weigh in their employment decisions. Among these are salary structures, benefit packages, working conditions and the location of the proposed employment.

Prisons are frequently at a disadvantage with respect to location. The decision as to where a new prison will be built is seldom made with any regard to the available labor pool of health professionals. Traditionally, prisons have been built in rural areas far removed from metropolitan centers, which, of course, is where most health professionals tend to cluster. If there is an oversupply of particular types

of clinicians in the metropolitan area, they may be willing to commute or to move to the more rural environment where the prison is located -- provided the prison's employment offer is attractive enough. On the other hand, if there is a shortage of health professionals of a certain type in the community, the prison's remote location may make it even more difficult to fill certain jobs even with competitive salaries and benefits.

Unfortunately, remote prison locations are an established fact. The best recruiter in the world cannot change what many view as a permanent disadvantage. Thus, it becomes even more important to review those aspects of correctional health employment that are amenable to change. Many people are willing to put up with some inconvenience in job location or to compromise their choice of where to live, if the job itself is attractive. This is not the case if the salary is low, the benefits are minimal and the working conditions are poor -- which, historically, is what correctional employment offered health professionals.

The development of an effective recruitment strategy involves first, deciding what to offer; second, reviewing employment practices; and third, identifying ways to reach the potential market. Each of these is discussed below.

1. Determining the Employment Package

The salary, benefits and working conditions of a particular job constitute the employment package. Each of these elements should be reviewed to determine the attractiveness of the employment package as a whole.

a. Salary Scales

It seems obvious that correctional health salaries must be competitive with those in other health settings if the goal is to attract qualified professionals, but what makes a salary competitive for a particular position is not always easy to define. One way to begin is to look at salary scales for the same position in several community markets (both rural and urban). Salary scales at other state agencies should be checked also.

Other salary factors such as raises, bonuses, promotional opportunities and overtime pay should be looked at as well as the base rate. Some DOCs offer "hazardous duty" pay for particular positions or provide a "shift differential" to compensate for less attractive working hours.

A comparative chart can be developed for each position that lists the employment settings in the first column (e.g., "University Hospital," "Community Hospital A," Community Hospital B," "State Public Health Agency," "State Mental Health Agency," "DOC") and summarizes the various salary factors in the other column headings (e.g., "base pay," "shift differential," "raises"). The time frame for earning raises or conditions for bonuses etc. should be specified also. It usually is not necessary to have strict comparability in all columns, if the overall salary components are somewhat similar. For example, it may be that the DOC's base pay for a full-time physician is somewhat less than that paid by a university hospital, but the DOC offers larger raises or gives them sooner. This may be enough to make the DOC competitive.

b. Benefits

The salary offered is just one component of the employment package. Individuals may be willing to take somewhat less in salary, if the benefits are attractive. Traditional benefits often include health and life insurance; vacation, holiday and sick pay; pregnancy leave; disability pay; and pension plans. Beyond these basics, though, there are some special benefits that deserve consideration.

1) Special benefits

There are several special benefits offered by employers in the "free world." Some of them are already in place in some DOCs. Others are readily adaptable to a correctional setting, while still others may be inappropriate. Some are realistic only for certain job categories while others can be provided to all employees. A few of them are discussed here only as a way of introducing the possibilities in improving a DOC's benefit package.

For health professionals, one benefit that can be attractive is providing subsidies for education. This can take many forms. Some states offer tuition reimbursement for courses taken in job-related areas. Others may subsidize training to upgrade the credentials of existing staff. For example, both the Florida and Texas DOCs paid for unlicensed corpsman to go to school to earn credentials as qualified health professionals. Educational subsidies benefit the health services division as much as the individual by improving the quality of staff and their level of skills, and by reducing "burn-out" and turnover.

Another variation of educational subsidies is to provide travel dollars and/or time off for health professionals to attend continuing professional education programs. Several states require continuing education as a condition for re-licensure for nurses etc. National certifying bodies such as the American Academy of Physician Assistants and NCCHC also require continuing education for recertification. Providing opportunities for health professionals to earn continuing education credits can be an important employment incentive that also benefits the DOC.

A related strategy that appeals to clinicians such as physicians, dentists and psychologists is the potential for affiliation with hospitals and/or academic institutions. A few DOCs have been able to offer faculty appointments for key staff. In some cases, correctional health practitioners serve as clinical faculty for students doing their rotations. In others, the DOC may provide release time for clinicians to teach at the affiliated university. This strategy has not been widely used in corrections, but has exciting possibilities that again may benefit both employees and the employer.

Additional employment inducements include such things as travel reimbursement for job interviews, moving expenses, housing allotments, free meals or other emoluments, job placement assistance for spouses etc. Regulations in some states may not permit DOCs to provide some of these benefits such as moving expenses. Others, though (e.g., meals or emoluments), may be offered routinely. The point of the benefit review is not to ensure that the DOC provides the same benefits as other employers, but rather, to ensure that what is offered by the DOC is competitive. A deficiency in one benefit area may be compensated for in another.

Other categories of benefits with potential applicability for corrections include family leave and child care programs, both of which have been topics of recent congressional bills. Offering a fixed amount of leave -- even unpaid -- to both males and females to attend to family matters such as the birth or adoption of a child or caring for an aged or ill family member could be one of the most important benefits employers offer in the future. Similarly, offering some assistance with child care (whether creating day care centers or subsidizing existing programs) may become a necessity for employers as the numbers of single parents and both parents working increase.

Two other benefits offered by some employers including DOCs are providing employee health care and employee assistance programs. Since they both have potential drawbacks, they are discussed in somewhat more detail.

a) Employee health care

In addition to health insurance, some DOCs offer some on-site health care as well. These can be minimal services such as annual tuberculosis screening for all employees or more costly services such as providing hepatitis vaccine for certain categories of employees most at risk. Both of these services may be worth considering owing to their public health implications. Other services, though, such as offering pre-service and annual physical exams or on-site ambulatory care to employees are not recommended. In the first place, there are substantial costs involved in providing on-site health care to employees. It is unrealistic to assume that the staff, space, equipment, supplies etc. designed to meet the health needs of a certain number of inmates also can meet the needs of staff. Under this arrangement, the inmates are likely to be underserved.

Equally important is the potential for conflict of interest. On the one hand, as employees of the DOC, health professionals may feel pressured to understate other employees' health problems, especially those associated with occupational safety issues or the employees' ability to work. On the other hand, they may feel uncomfortable knowing intimate details about the lifestyles and health status of their colleagues. Alternatively, the employees served may be less than forthcoming about their health problems, because they do not want their colleagues or their employer to have access to this information.

In effect, then, what seems like a benefit may actually work to the detriment of all involved. This is an avoidable conflict and except for emergency situations where the "good Samaritan" principle may apply, it is recommended that DOCs not offer ongoing health care to employees. If, in spite of the problems, a DOC decides to offer this benefit, then the employee health program should be totally separate from the inmate health program. It should have its own space, its own staff, its own records -- in short, its own budget -- and its own medical autonomy. The latter is especially necessary if the employee health unit has the responsibility of certifying staff's "fitness for duty," whether as a part of annual physicals, disability claims, workers' compensation etc.

b) Employee assistance programs

Working in corrections can be a highly stressful situation. Additionally, many correctional employees are at risk of developing illness and disease owing to their smoking and drinking habits, improper diets and lack of exercise. Some DOCs offer wellness programs such as stress management courses or smoking cessation clinics that address some or all of these problems. Wellness programs are to be encouraged since they are essentially health education efforts that do not require employees to reveal much about themselves other than that they are stressed or overweight or smokers or couch potatoes. Employee assistance programs (EAPs), though, are a different matter.

EAPs are designed to provide short-term counseling and referral services to employees whose personal problems have begun to affect their job performance.[9] They usually go beyond the habit control efforts that are the focus of wellness programs and address problems of a more intimate nature (e.g., marital difficulties, alcoholism, drug abuse, psychological problems). EAPs can benefit employees by giving them a place to turn when they are in crisis, and employers by reducing turnover and sick leave, for example. Their main drawback is the same as that for providing employee health care onsite. The success of an EAP is dependent upon the amount of trust that employees have that their secrets will not be revealed to their colleagues or their employer. Therefore, strict confidentiality must be maintained. If a DOC decides to initiate an employee assistance program, it, too, should be entirely separate from the inmate health services program with its own budget and its own autonomy.

2) Benefit review

As with salary scales, it may help to lay out a chart that summarizes the benefits offered by the DOC versus those offered by other state agencies and community organizations involved in the comparison study. Again, the employment settings are placed in the first column and the benefits offered comprise the other column headings. The number of days allowed for specific benefits along with eligibility requirements and any special conditions should be stated. The more detailed the information, the easier it is to determine the extent to which the DOC's benefit package is competitive. A deficiency in one area may be compensated for in another. For example, the DOC may offer fewer vacation days but more holidays, or it may offer a less attractive health plan initially than some other group, but increase its percentage of premium coverage over time.

c. Working Conditions

The third area of comparison in employment packages involves working conditions, which, in essence, embraces everything other than salaries and benefits. They include the number of hours and days worked as well as the workplace itself and the general ambience.

Health professionals are used to shift work, so the fact that prisons often require 24 hours per day, seven days per week coverage is not usually a problem. Many people, though, do not like to rotate shifts. A position may be considered more attractive if the hours and/or days worked can be guaranteed. It is worth noting that not everyone wants to work 9am - 5pm Monday to Friday. Family obligations and/or a spouse's work schedule may make other shifts or days off of interest to a number of individuals. Even if work hours and days cannot be guaranteed to new employees, it may make the position more attractive if the applicant knows that s/he can work into a fixed schedule.

Other aspects of scheduling that may appeal to health professionals are flex time and position sharing. State agencies are sometimes prevented from utilizing these more creative scheduling options, but where they are not prohibited, they can help in recruiting individuals for hard-to-fill positions. Similarly, if the state permits part-time employment, this can be a cost-effective option for certain positions where full-time personnel are not required. Alternatively, professional service contracts can be utilized to obtain coverage for part-time positions.

The workplace setting is another aspect of working conditions that can influence individuals' employment decisions. Health professionals are more likely to be interested in working in a clinic that is clean, spacious and well-equipped than one that is dingy, cramped and without modern tools. The inside of the health services area should look like a clinic, not a prison. It should mirror community facilities as much as possible even though perimeter security is required.

One built-in disadvantage of a prison in attracting health professionals is its ambience. For the uninitiated, the atmosphere can be oppressive and recruiters must be prepared to counteract the basic fear of inmates generated by countless movies

and television shows. Probably the question most frequently asked by health professionals contemplating prison employment is "Is it safe?" Contrary to popular opinion, physical assaults against staff are not common. While no one has calculated exact rates, some of the statistics gathered by Camp and Camp can be used to develop rough estimates.[10] Of the almost 300,000 employees working in the state and federal DOCs on January 1, 1990, less than one percent had been involved in an assault during 1989 that required any medical attention. Unfortunately, breakdowns were not provided by type of staff (e.g., correctional, medical) nor by severity of injury. The fact is, though, that the overall rate was very low and it is likely that the proportion of health professionals physically assaulted annually is even lower. It is recommended that all DOCs gather information about physical assaults against staff, broken down by type of institution, by type of staff and by severity of injury. Such information could be extremely useful for recruiting purposes to help dispel the notion that all prisons are inherently dangerous places in which to work.

2. Reviewing Employment Practices

Correctional institutions often exclude certain categories of individuals from employment. Sometimes the employment restrictions are legitimate. For instance, a security clearance for all employees including health professionals is a necessary precaution and for some positions, age or physical ability requirements may be reasonably related to the job. In other instances, though, the employment restrictions of DOCs are not legitimate such as the traditional exclusion of women in jobs "behind the walls." While DOCs in some states have recognized the impracticality of automatically excluding half of the human race from employment, others have not. Aside from potential litigation, the reluctance or refusal to hire women to work in prisons can hamper the DOC's ability to fill its jobs with qualified personnel. Such a practice can be devastating in attempting to fill certain health positions (e.g., nursing) where the vast majority of the labor pool is female.

Aside from ensuring that the DOC is adhering to relevant federal regulations regarding non-discriminatory hiring practices, the steps involved in the pre-employment application and interview process should be scrutinized. If the pre-employment process is too onerous or too offensive, potentially valuable employees lose interest. Typical problem areas include outdated or inappropriate questions on the application itself,[11] excessive waiting time to be photographed and/or fingerprinted, questionable practices such as conducting credit checks or invasive character reference checks, and lengthy delays in obtaining security clearances. The latter problem is of particular concern. If it takes two or three months or longer to obtain an employee's security clearance, the time and effort spent in recruiting and selecting potential health staff can be wasted, since the individual may lose interest or take another position.

3. Reaching the Potential Market

After reviewing what the DOC has to offer in its employment package and ensuring that its employment practices and pre-employment processes do not act as disincentives, the final step in recruitment is identifying and reaching the potential labor markets for available positions. Common techniques include advertising in professional journals and national publications, targeted mailings and in-person solicitations.

Almost all of the health professions have a national membership association and many have state associations as well. The publications of these groups are a natural place to advertise available health positions. Additionally, the National Commission on Correctional Health Care has a quarterly newspaper *CorrectCare*, and the ACHSA has a bi-monthly newsletter "CorHealth," both of which are distributed to correctional health professionals. The former has a circulation of about 15,000 and the latter a circulation of about 1,500. Both of these organizations accept display ads as well as classified advertising.

Targeted mailings are another recruitment strategy. The trick here is to identify the most promising labor pool. Generally, the wider the distribution of brochures or promotional materials, the lower the rate of return. If a particular area of the state has several nursing positions open, it may be more effective to send a mailing to nurses already working in that area, comparing the DOC's employment package with other local markets, rather than trying to attract nurses from elsewhere. Information about employment rates of particular health professions can help to determine which groups to target.

Probably the most effective strategy, though, is in-person solicitation. This gives potential applicants

an opportunity to ask specific questions about salaries, benefits and working conditions and gives recruiters a chance to dispel any myths or misconceptions about working in a prison. Many colleges and universities with health science curricula hold job fairs for upcoming graduates. This can be a place to start. Another opportunity that should not be overlooked is the possibility of exhibiting at annual meetings of health professional associations or correctional health care conferences such as those sponsored by NCCHC or ACHSA.

C. The Selection Process

Hiring new employees is always something of a gamble. When you deal with people, there is no such thing as a "sure thing." Even individuals with excellent credentials and impeccable references do not always make good employees, or they may not adapt well to the prison environment. Still, the odds of hiring people who fit the job are improved if the position requirements are specified in some detail. Developing written job descriptions for each type of health care position is a good way to start.

Written job descriptions are required by all four sets of national standards used in corrections (see Appendix E, section II.A.1.). They should specify the duties and responsibilities associated with each job title and spell out the minimum qualifications of the person(s) holding that title.

In any given state system, there may be three types of written employment descriptions. The first is a state civil service classification such as "RN II" or "psychologist I" that may be used in all state agencies. These classifications are usually very general and are used to determine pay rates. The second type of written employment description is one that is specific to the agency. Several individuals may have the same civil service classification, yet have different job titles in the department of corrections. For example, one RN II may have the title "charge nurse" in a larger facility, another may be the "head nurse" in a small facility and still another may be the "quality assurance coordinator" in central office. Each separate job title requires a separate job description.

In addition, some job titles also may require post descriptions, which is the third type of written employment description. Post descriptions define the exact duties of an individual at the unit of assignment on a given shift (e.g., "infirmary nurse, night shift" or "intake nurse, day shift"). Thus, a single individual may have a pay classification of "RN I," hold the job title of "staff nurse" and be assigned to the post of "medication nurse, evening shift" at a specific prison unit.

Written job descriptions (and post descriptions where applicable) should be drafted in sufficient detail to determine what qualifications are relevant for the individuals holding that job title (or post). They should be reviewed annually and updated as needed.[12] The format for job descriptions should include the following elements at a minimum: the job title, who developed the description, who approved it, the date it was issued, the date(s) it was reviewed, the specific duties and responsibilities of the job, and the minimum qualifications of the person filling it (see the sample format in Exhibit VI-C).

In establishing the qualifications for a specific job, whatever is listed should be the minimum required. Sometimes, job descriptions are written to reflect the ideal qualifications for a given title and then certain of the requirements are waived when suitable applicants cannot be found. A better practice is to decide what is the least qualifications that the job requires and then give preference to candidates who may exhibit more in terms of education, experience etc.

For health professionals, the one qualification that must never be waived is that of credentials. If the duties and responsibilities of a particular job dictate the employment of a registered nurse, hiring a licensed practical nurse will not do; nor will hiring an unlicensed individual nor one with an "institutional license" only. The basic requirement for any correctional health job is that individuals be licensed, certified or registered the same as they are required to be for comparable positions in community health settings. This is an absolute requirement of all four sets of national standards (see Appendix E, section II.A.1.) and has probably done more to upgrade the quality of correctional health services than any other single stipulation.

In the past, it was not uncommon for a prison health unit to be staffed by some combination of inmate workers, unlicensed corpsmen, and practitioners with "institutional licenses" (e.g., impaired physicians who had lost their community licensure or foreign medical graduates who had not passed the necessary exams for licensure) with perhaps only an occasional properly credentialed staff member. Those days are over. While there still may be state correctional systems that use non-credentialed individuals to provide health services,

EXHIBIT VI-C

Sample Job Description Format

Job Title

Developed by _____ Date Issued _____

Approved by _____ Date(s) Reviewed _____

A. Duties & Responsibilities

1.
2.
3. (etc.)

B. Minimum Qualifications

1. Education
2. Credentials
3. Experience
4. Special requirements

Education refers to the formal training an individual may have received in school. Depending on the job title, requirements may be specified in years (e.g., "two years of college"), in degrees (e.g., "master's degree," "associate's degree"), or their equivalent (e.g., "high school diploma or equivalent such as GED"). *Credentials* refers to the specific licensure, certification or registration needed to hold a particular job (e.g., "RN licensed in the state," or "physician assistant-certified," or "registered dietitian"). *Experience* should reflect the number of years worked in a particular field or job category (e.g., "a minimum of five years in correctional nursing at least two of which must have been in a supervisory capacity" or "no experience required"). *Special requirements* include those elements unique to a particular position such as possessing a valid driver's license or the ability to travel or the ability to operate certain equipment or to speak a foreign language etc.

they clearly are the exception and not the norm.

These days, almost everyone agrees that medical and dental personnel working in corrections should be appropriately licensed, certified or registered the same as their community counterparts. There is still some disagreement, though, in two areas; namely, requirements for mental health personnel and the use of inmate workers in the prison health unit.

With respect to mental health personnel, part of the problem is simply in determining what is the national norm. State licensure generally is required for traditional medical staff working in mental health such as physicians and nurses. In many states, however, other mental health personnel such as psychologists, therapists, social workers etc. are not required to be licensed or the state exempts those individuals working in corrections from licensure requirements or only certain categories of professionals require licensure (e.g., PhD clinical psychologists but not master's level personnel) or individuals can be hired without licensure, but must obtain one within a specified period of time. Any or all of the above combinations may apply for different types of mental health professionals in a given state.

The lack of uniformity in state requirements for licensure of mental health professionals makes it difficult to say precisely what the norm should be for corrections. The basic tenet, though, is the same as that for other health professionals; namely, that the community standard prevails. In other words, if a state does not require licensure for psychologists practicing in the community, those working in corrections need not be licensed either. What is not acceptable -- at least under NCCHC's standards -- is for correctional personnel to be exempt from community practice requirements or to be held to a lesser standard.

The second area where some controversy remains concerns the utilization of inmate workers. The three sets of standards designed for corrections (i.e., NCCHC's, APHA's and ACA's) all prohibit inmate workers from providing direct patient care, determining access of other inmates to health services or handling medical records. The ACA's standards (1990: 113), though, permit "...inmates participating in a certified vocational training program [to] perform direct services, such as dental chairside assistance," while those of the NCCHC and APHA do not.

At first glance, it may seem appropriate to provide inmates with vocational training opportunities in the health services, but there are problems with this approach. First, in many states, for many of the health professions, conviction of a felony automatically disqualifies individuals from obtaining licensure, certification or registration. Therefore, whatever skills an inmate may learn in a health vocational program cannot be translated into employment opportunities on the outside. More important, however, are the problems created on the inside by having inmates work in the prison health unit.

Maintaining confidentiality of medical information is difficult enough in prisons. The presence of inmate workers in the health area makes it impossible. Even if the medical records are guarded zealously, staff tend to discuss patients among themselves. Further, the inmate worker can claim special influence with the health staff or alternatively, be subjected to pressure from other inmates to obtain drugs, needles, sharps, supplies or simply, information. Finally, there is the potential for increased liability should an inmate worker cause harm to another inmate in the course of the vocational activity.

All of these reasons argue against permitting inmates to work in the health unit. Further, even when inmate workers are used to clean the health area (which is allowed by ACA's, APHA's and NCCHC's standards), they must be kept under constant observation. They should come in, clean and leave. It is poor practice to assign inmate workers to the health area for a full shift even if their specified duties are only to clean. For one thing, staff members are invariably tempted to use them for other duties (e.g., to run errands, to carry records, to lift patients) and for another, staff tend to forget their presence when discussing patients.

In some prisons, there are vocational opportunities for inmates to make health products (e.g., dental prostheses, orthotics) rather than to provide health services. Such activities are permissible under NCCHC's standards as long as two conditions are met: first, the laboratory or work area must be totally separate from the main clinic area and second, a coding system must be used to protect the identity of the patients receiving the protheses.[13]

D. Staff Development Programs

Another personnel consideration is to determine the type and extent of training that staff should receive. Both correctional and medical staff have training needs, but since the role of the health

services unit differs with respect to that training, they are discussed separately.

1. Health Staff

Newly hired health staff require orientation to the prison environment and all health employees benefit from ongoing training opportunities. The primary decisions that the statewide health services director (HSD) needs to make concern the content of the training, the length and frequency of course offerings, who should receive them and who should conduct them.

a. Orientation

Orienting new employees to the prison environment and to the health services division helps to familiarize them with rules and regulations and to avoid certain pitfalls. While the clinical aspects of medicine in corrections may be similar to the community's, the setting and the patients usually are not. The orientation program for new health employees should focus on these differences as well as on the similarities between correctional and community practice.

Security is the overriding concern in correctional institutions and as such, all new employees must be aware of security issues. It is important, though, to remind health staff that they are not security officers. Their primary role is to serve the health needs of their patients. Another group of professionals is responsible for performing the various custody functions.

Some state DOCs as well as the federal system still require new health staff to undergo the same initial training as new correctional staff. In the author's opinion, this is not the right approach. Health staff do not need training in weaponry, riot control and use of force, which are the province of correctional professionals. While they may need exposure to some of the same issues as correctional staff, they do not need the same intensity of training. Having a single orientation program for all staff not only wastes the clinicians' valuable time in learning material and skills that will not be used, but also fails to address those issues specific to health services that new health employees need to know. Further, training health professionals first as correctional officers makes it more difficult for them to maintain their role of neutrality in non-medical issues and to avoid co-optation by security officials on health matters. Thus, separate orientation programs for new correctional and health staff is a better approach than joint orientation, even though both groups need some awareness of the other's concerns and regulations.[14]

Another topic that should be addressed in orientation for new health staff is defining the population to be served and describing the inmate social system. Information about who goes to prison, including their ethnic and class makeup, can be useful as can any epidemiological data or description of special health needs of the inmates in the system. Also, some mention should be made of the "games inmates play" in attempting to manipulate the health staff for their own purposes. Since new staff are particularly vulnerable, it is a good idea to review some of the ways inmates may try to "con" them into providing unneeded services or violating prison rules. Often, much is made of the manipulative nature of inmates. It is worth remembering, though, that clinicians are "conned" in all settings, public and private. The motives and methods of inmate/patients may differ, but the concept of manipulation is not unique to the correctional environment.

The orientation program also should contain information about the organizational structure of the department of corrections, the health services division and the various prison units. The rules and regulations of the DOC as a whole as well as the health services policies and procedures should be reviewed. The orientation program generally does not cover specific job responsibilities. It is anticipated that additional instruction on particular tasks and duties will be provided on a one-on-one basis at the employee's work station. Other topics that may be addressed in initial orientation for health professionals include an overview of the criminal justice system; an introduction to corrections including its purposes and terminology, and sometimes, inmate slang; and general personnel policies. Throughout the orientation, it is important to remind health professionals that although the setting is different, the basic precepts, principles and standards of their own disciplines remain the same.

The length of the orientation program may vary, but two or three days should be the minimum. When it is offered is a more important consideration. Ideally, new employees should be oriented to the system before reporting to their work stations. Larger DOCs usually can adhere to this timetable, since they may have several new health employees starting at about the same time or they may specifically schedule starting dates to coincide with

orientation offerings. Smaller departments may have to balance the employees' need for timely orientation with practical considerations regarding class size. Still, orientation should occur within the first month or two of employment for it to be worthwhile.

NCCHC's standards require that initial orientation be provided to all full-time health personnel.[15] Consideration should be given to including regular part-time employees and consultants in orientation programs as well. Often, they are excluded because the health services director does not want to pay for their time while in training. This can be short-sighted, though, since these individuals also need an awareness of security issues, health services policies and procedures, and the patients they are serving.

Who should conduct the orientation is another issue. In the larger DOCs, there may be a health education section in central office. Health educators may teach the orientation themselves as well as draw on the expertise of department officials or other guest lecturers for various components of the curriculum. In smaller DOCs, the orientation may be provided by a co-worker on a one-on-one basis. Who conducts it is less important than having a set curriculum, which is reviewed with all new employees on a timely basis.

b. In-service Training

The term *in-service training* as used here is intended to encompass a variety of training activities ranging from instruction provided on-site to formal continuing education offerings. Its primary purpose is to ensure that health staff are kept up-to-date on clinical issues and administrative procedures. Its primary benefit is that of improving the quality of care and secondarily, reducing staff "burn-out." Any job can become boring over time and it is easy for staff to become jaded about their work or the patients they serve. Providing periodic opportunities for employees to escape their routines helps to improve their skills and morale as well as re-emphasize the goals of the health care system.

It is not possible to specify the exact content of a "model in-service program" for correctional health professionals. Not only do requirements differ among states, but among the various health disciplines as well. Similarly, there is no standard number of hours required across states or disciplines. NCCHC's standards mandate a minimum of 12 hours of in-service training annually for all full-time health care providers,[16] but individual practitioners may need more or fewer hours to maintain licensure or certification.

Thus, each DOC should develop its own in-service training plan that reflects the requirements of its own state and the needs of its own personnel. It does not matter where the training is offered, only that various opportunities be provided for employees to attend in-service programs and to obtain formal continuing education credits. Some DOCs conduct almost all of the training themselves using their own instructors and guest lecturers. Others allow their employees to attend in-service programs offered by community hospitals or other state agencies or to participate in annual conferences of state or national health groups.

Regardless of the approach taken, it is important to document all training received by each health service employee. Individual records should list the courses taken, the dates and the number of hours. This information should be maintained in their personnel files and be accessible to supervisory staff.

2. **Custody Staff**

Determining the training needs, schedules and curricula for custody staff is not the province of the health services division. Nonetheless, most of the sets of national standards (i.e., all except JCAHO's) require correctional officers to have some training in health-related issues (see Appendix E, section II.C.5.a. for specific requirements). Health personnel can be helpful in designing or reviewing proposed curricula and in serving as instructors for certain courses.

Health-related topics for custody staff may include formal training in first aid and cardio-pulmonary resuscitation (CPR) as well as training regarding their role in managing special needs inmates such as those who may be mentally ill, HIV-positive, mentally retarded, suicidal, chemically dependent etc. Health staff also may offer educational programs for their correctional colleagues regarding infection control practices, stress management, occupational safety or environmental health issues. The involvement of health professionals in conducting such courses can help to improve the relationships between custody and medical staff as well as to ensure that the clinical information presented is accurate.

E. Conclusions

This chapter has focused on the more major staffing issues that confront administrators. Its purpose was to address the health staffing concerns that differ in a correctional environment. A number of other personnel matters common to all settings, such as performance evaluations and disciplinary measures, have not been addressed. There are entire manuals devoted to these and other personnel topics that administrators are encouraged to explore.

Staff is the primary resource of all correctional health systems. The decisions made regarding their recruitment, selection, training and development have enormous impact on the likelihood of successful attainment of the delivery system's goals. Failure to devote sufficient time, effort and dollars to staffing issues reduces the quality of care and increases the probability of litigation.

ENDNOTES

1. See Chapter V, section B for a description of the survey and its methodology.
2. Alabama, Arizona, Indiana, Louisiana and South Carolina.
3. Missouri and Virginia.
4. See Appendix E, section I.B.
5. See Chapter VIII for a more complete discussion of inmates with special health needs.
6. Generally, mental health services are the most neglected in terms of space considerations. Because counseling does not require any special equipment, it frequently is assumed that it can be conducted in any vacant room. Sitting on stools in an empty lab or radiology room may provide the necessary privacy for the therapist and client, but is scarcely a therapeutic environment and certainly not a professional one. The impact of space on services is discussed more fully in Chapters VII and X.
7. APHA's standards (Dubler, 1986:104) require one FTE physician for every 200-750 inmates without regard to the correctional setting (i.e., jail or prison). NCCHC's standards recommend one FTE physician for a prison population of 750-1000 (1987a:10) and one FTE physician for a jail population of 500 (1987b:11).
8. Benton (1981:14-17).
9. See Bosarge (1989: 269-274).
10. See Camp & Camp (1990), pages 49 & 50 and pages 21-22.
11. Some DOCs make the mistake of asking all potential employees the same questions. While it may be appropriate to require entry level COs to produce a copy of a high school diploma, a physician may find that same requirement silly or annoying. Similarly, it is not relevant to ask all potential staff what office machines they can use and at what speeds.
12. See NCCHC (1987a), standard P-16.
13. NCCHC (1987a:13).
14. It is recognized that not all correctional health administrators would agree with the author's views. Some feel strongly that health staff should receive the same orientation as correctional staff, both to increase their identification with their correctional colleagues and to provide back-up assistance in the event of a riot, escape etc.
15. NCCHC (1987a: 10-11).
16. *Ibid.*

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CHAPTER VII

HEALTH CARE DELIVERY SYSTEM MODEL

In the staffing chapter, it was stated that the primary determinant of the types and levels of staff was the services offered at a particular facility. This chapter discusses the basic components of an adequate health delivery system. The chapter begins with a comparative analysis of national standards, since their requirements provide the framework for the delivery system model. Section B reviews some of the more important elements of the medical program including basic ambulatory care services such as intake, sick call, medication distribution and chronic clinics as well as specialty care, inpatient care and emergency care. Section C focuses on the mental health program. Topics such as intake procedures, crisis intervention, outpatient treatment and inpatient care are presented. Elements of the dental program are outlined in Section D. The chapter concludes with a brief discussion of some of the ancillary services that support the health programs and the need to coordinate health services with custody staff.

A. Comparative Analysis of Standards

There are four sets of national standards that are used to govern correctional health care in the United States: those of the American Correctional Association (ACA),[1] those of the American Public Health Association (APHA),[2] those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),[3] and those of the National Commission on Correctional Health Care (NCCHC).[4] Other professional associations such as the American Nurses' Association (ANA),[5] and the American Psychiatric Association (APA),[6] have developed correctional health standards for their areas of expertise, but the four sets noted previously are more comprehensive in covering the range of health services to be provided.

While the four sets of national standards have some requirements in common, there are enough differences to prevent discussing them as if they were a single entity. At times, the sets of standards disagree on important issues. In constructing the health delivery system model, those of the APHA and NCCHC were relied on most heavily. Both of these sets of standards were developed by health professional associations specifically for corrections and are consonant on most issues. They tend to complement one another in the areas addressed and the extent of detail provided.

Appendix E consists of a chart that summarizes the requirements of the four sets of national standards with respect to management concerns and delivery system components. Each set has its own advantages and disadvantages, and thus, they do not work equally well in applying them to correctional health care systems.

The primary advantage of the ACA's standards is that they were developed by the most prominent correctional professional association and hence, many correctional administrators and commissioners of DOCs are likely to be familiar with them. In a sense, though, this is also their primary disadvantage from the perspective of health professionals. Where there are potential areas of conflict between custody and medical staff -- particularly related to ethical concerns such as involving health staff in custody procedures -- the ACA's standards tend to stand silent or adopt the security perspective. Additionally, health services is not the focus of the ACA's standards, since they were designed to cover all aspects of the administration and operations of prisons.[7] Of the 363 standards in the ACA's 1990 edition for adult correctional institutions, only about 15 percent are specific to health (N=54).

Further, while the health care section of the ACA's standards addresses many of the same topics as NCCHC's and APHA's standards[8], they are the least comprehensive and suffer from a lack of detail. ACA's health care standards seldom include discussion, commentary or examples that could assist health professionals in implementation. Finally, the ACA designates few of its standards as mandatory for accreditation. Only 38 of the total 363 are mandatory, 11 of which are health care standards.

The Joint Commission on Accreditation of Healthcare Organizations is the preeminent accrediting body for community health care. It has a series of separate standards volumes for facilities with various health missions including hospitals, ambulatory care clinics, mental health facilities, substance abuse programs etc. Of these, the set for ambulatory health care fits most correctional institutions' basic health mission better than the other sets by JCAHO.[9] The primary advantage of

utilizing JCAHO's ambulatory care standards is that they do reflect the "community standard of care," since they are used in community facilities. Another strength of the JCAHO's standards is their emphasis on quality assurance.

Their primary disadvantage is that they are not specific to corrections and hence, do not address topics such as the role of health staff in evidence-gathering or inmate disciplinary actions, health training of correctional staff, intake procedures, sick call etc. Also, the ambulatory health care set addresses medical services only and not dental or mental health programs. Finally, JCAHO's requirements are stated in very general terms and no commentary is provided to assist managers with implementation. For example, several standards refer to the need to receive reports (e.g., laboratory, radiology) "in a timely manner," but there is no definition of "timely." Similarly, JCAHO's standards require "available and accessible" health services, but these terms are not defined.

The standards developed by the American Public Health Association address a number of the problems identified with the standards of ACA and JCAHO. APHA's standards were developed by a health professional association and thus, emphasize the perspective of health professionals. These standards are comprehensive (covering medical, dental and mental health services) and they are specific to corrections. Additionally, they are sufficiently detailed in their requirements to provide some guidance to individuals regarding implementation. Overall, APHA's standards are very good as a set of principles, but have two basic problems in applying them to correctional institutions.

First, these standards purport to apply to large state prisons as well as small county jails, which is not always practical. For example, one component of the standard on entrance examinations for women states that "...plans must include...continuation of contraceptives for women who request it."[10] This is a reasonable requirement for facilities holding women for short terms, but not for most prisons where it is assumed that contraceptive devices will not be needed for most women during their stay. Similarly, APHA's standards state that "sick call shall be at least five days weekly,"[11] which makes sense for larger institutions but not for smaller ones. Second, the absence of an accreditation effort associated with APHA's standards makes it difficult to judge whether compliance has been achieved. This means that the interpretation of the APHA's standards and the measurement of compliance are left to the individual practitioners using them.

The standards of the National Commission on Correctional Health Care have many of the same advantages as those of APHA. NCCHC's standards were developed by representatives of a number of health professional associations, using the prior standards of the American Medical Association (AMA) as a base. NCCHC has separate sets of standards for prisons, for jails and for juvenile facilities, and size differences are taken into account as well. This makes them more practical than APHA's. NCCHC's standards also have the added advantage of being more measurable, since compliance levels are established through an ongoing accreditation program.

The primary disadvantage of NCCHC's standards is that certain important areas such as environmental and occupational health issues are not addressed adequately. Taken together, though, the APHA and NCCHC standards make a very good set, since the deficiencies in one tend to be off-set by the strengths of the other. The requirements of these two sets form the basis for the discussions below on components of the medical, mental health and dental programs.

B. The Medical Program

The components of the medical program addressed below include basic ambulatory care services, specialty care, inpatient care and emergency care. With the exception of ambulatory care services, most prisons do not offer every service in-house, nor is this necessarily recommended. In most DOCs, the patient base for certain special services and programs is not large enough to justify offering every service in every institution. Instead, the decision is made as to which basic services will be decentralized (i.e., available at every prison) and which will be available only on a regional or a statewide basis. The factors that must be considered in making such a decision (e.g., patient load, cost, geographic location, custody class and other security issues) are described in Chapter X.

1. Basic Ambulatory Care

a. Intake Procedures

Every prison needs to have established procedures for medical intake. What those

procedures consist of may differ depending on the DOC and the mission of individual prisons. In most systems, there is a single designated statewide reception center through which all inmates sentenced to the DOC are admitted. In some states, though, the intake function may be regionalized and in a few states, several institutions perform an admitting function. Regardless of whether inmate admission to the DOC is centralized, regionalized or decentralized, staff at the first prison in the system at which an inmate appears must conduct the initial health screening and assessment.

1) Receiving screening

While most individuals come to prison directly from jails, very few of them are accompanied by any medical information. Additionally, some inmates come to prison from the street (e.g., those who previously made bail, parole violators). In either case, it is imperative that certain basic health data be gathered on each new arrival immediately upon admission to the prison system. A qualified health professional should observe and interview every inmate within the first couple hours of his/her admission to the prison system. The purpose of this receiving screening is essentially triage; that is, to determine which inmates need to be referred for care immediately, which need to be set up with medications or scheduled for follow-up care, and which inmates safely can wait to be seen according to the usual health admission procedures.

According to NCCHC's standards (1987:22), at a minimum, the screening process must include:

- *Inquiry into current illnesses, health problems, and conditions:*

  mental, dental and communicable diseases; medications taken and special health (including dietary) requirements; for women, current gynecological problems and pregnancy; use of alcohol and other drugs, including types, methods, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions); other health problems designated by the responsible physician.

- *Observation of the following:*

  behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, and sweating; bodily deformities and ease of movement; and condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations, and needle marks or other indications of drug abuse.

- *Administration of a test for tuberculosis.*

- *Notation of the disposition of the patient, such as immediate referral to an appropriate health care service, placement in the general inmate population and later referral to an appropriate health care service, or placement in the general inmate population.*

The results of this receiving screening should be recorded on a standardized form and a copy placed in each inmate's medical record. For first time offenders, the receiving screening form initiates the medical record. For recidivists, the prior medical record should be reactivated.

It is important that the DOC's policy statement on receiving screening include specific guidelines for disposition. In other words, the health screener should know what procedures to follow and what forms to complete to ensure that any patient needs identified during that screening process are attended to in a timely fashion.

2) Health appraisal

The intent of receiving screening is to gather enough basic information about each new arrival's health needs to ensure continuity of care and to prevent avoidable medical emergencies. It should be followed by a more detailed health history and examination within the first week of each inmate's incarceration. Health appraisal data should be recorded on standardized forms and placed in each inmate's medical record.

The full health appraisal includes a number of steps. Generally, it begins by reviewing the receiving screening forms and gathering additional data to complete the inmate's medical, dental and mental health histories. Information should be solicited regarding past illnesses and hospitalizations as well as current health complaints, medications and treatments. The patient's family history of certain genetic-linked diseases should be included on the form along with the individual's immunization status and known allergies. If height, weight and vital signs

were not taken as part of the initial screening, they should be obtained and recorded. At some point during this process, each inmate should receive information about the procedures for accessing health services and for filing medical grievances.

Depending on the time frame between admission and the health appraisal, the patient's reaction to the tuberculin skin test applied at screening should be read or recorded. Additional laboratory tests to detect communicable diseases (e.g., syphilis, gonorrhea) and for other diagnostic purposes (e.g., urinalysis, pregnancy test for females) should be conducted. Vision tests and hearing tests should be done along with mental status exams and dental exams.[12]

A physical exam by a physician or physician extender (e.g., NP or PA) completes the health appraisal data collection. The exam should consist of a "hands on" assessment of the major organ systems, including a pelvic exam and a Pap smear for females.[13] It is suggested that the form used to record the physical exam results simply list the body parts and systems reviewed and leave space for comments. When the form includes "normal" and "abnormal" columns, examiners often are tempted to draw a line down the "normal" column, which makes it difficult to verify that each body part or system has been reviewed.

The final step is for the examiner to review all data collected, specify the medical problems identified and develop an appropriate treatment plan that provides instructions regarding "diet, exercise, medication, the type and frequency of laboratory and diagnostic testing, and the frequency of follow-up for medical evaluation and adjustment of treatment modality" (NCCHC, 1987: 37). While much of the health appraisal can be completed by health personnel who are not physicians, the hands-on exam, the identification of problems and the development of treatment plans must be done only by a physician or a physician extender. In the latter case, a physician still should review and co-sign the extender's chart entries.

It is not necessary to repeat the receiving screening nor the full health assessment at each institution in the DOC to which an inmate is transferred. However, it is imperative that each patient's health record accompany him/her upon transfer. Staff at the sending institution should review the record to ensure that it is complete. In some systems, a brief transfer summary is filled out that lists current medications, treatments, scheduled appointments etc. Medications may be transferred at the same time as the inmate. Health intake at the receiving prison consists of health staff reviewing the chart of each transferred inmate on the day of transfer and taking the necessary steps to ensure continuation of medications, diet, and other care and treatment regimens.

There are a couple of other issues associated with receiving screening and health assessments that should be addressed -- one is their frequency and the other concerns refusals. As to the former, it usually is not necessary to repeat the receiving screening done on the day of admission during an inmate's confinement. If an inmate is discharged from the DOC and returns or goes out on extended furlough, a new screening form should be completed. Otherwise it is not relevant, since more detailed and more current health data should be available in the patient's chart. As to the health appraisal data, at a minimum even for young, healthy inmates, there should be an annual review of each patient's chart and a tuberculin skin test (unless contraindicated). The need to repeat other laboratory or diagnostic tests or to initiate new ones or to conduct another hands-on assessment is dependent on the inmate's age, need and risk factors. It is suggested that each DOC have its clinical director develop protocols that define the frequency and extent of repeat health appraisal data collection for inmates in different age, gender and risk groups. The guidelines published by a number of medical specialty societies (e.g., American College of Obstetricians and Gynecologists, American College of Physicians) can be extremely useful in developing such protocols.[14]

The issue of inmates' refusal of all or part of the health appraisal process is problematic. For the most part, competent inmates have a right to refuse medical care and treatment, which certainly extends to the health appraisal data collection process. They even have a right to refuse communicable disease screening, although when this occurs, medical staff can order that the inmate be quarantined to protect the health of others if there is sufficient clinical justification for doing so. Usually, all that is necessary to get a recalcitrant inmate to agree to the testing is to explain that s/he cannot be placed in general population until the testing is completed and communicable diseases are ruled out. Suppose, though, that an inmate agrees to the communicable disease testing, but refuses all other tests and exams and will not cooperate by providing health history data? That is the inmate's right and all the health staff can do is to explain to the inmate that the sole

purpose of the information is to meet his/her health needs.

In good health systems, inmates rarely refuse to participate in the health appraisal process. They understand that it is done for their benefit and cooperate willingly. If an institution is experiencing a high percentage of refusals, it is likely that there are some disincentives built into the process. It may be that health staff are allowing inmates to refuse the health appraisal by notifying a correctional officer instead of insisting that all inmates scheduled be brought to the health unit, so that the purpose of the data collection process can be explained. Sometimes, a high refusal rate can be traced to an over-zealous lawyer who has fashioned a complex consent form that frightens or intimidates the individuals. In most instances, it is not necessary even to provide a separate written consent form for the health appraisal, since there are no invasive procedures except drawing blood and even here, the potential risk of complications or injury is negligible. If a prison is experiencing a high rate of refusal of the health assessment process, it is suggested that health staff interview a sample of inmates to determine why they refused. The results of such a study may suggest procedural changes that will reduce the refusal rate.

b. Sick Call

The backbone of any correctional health delivery system is its sick call process. Every prison should have a mechanism in place that enables all inmates -- including those in segregation -- to request health services daily. Some DOCs allow inmates to make verbal requests for care or simply to appear at the health unit. In others, health staff make daily rounds of each housing area. Some DOCs utilize a written request system and some use a combination of these procedures. A written request system coupled with staff rounds of inmates on lock-down status is probably the best system, since it is most likely to ensure that all inmates have an opportunity to voice their health needs daily. It also ensures that there is documentation of inmates' requests and the daily patient load can be regulated better than a walk-in system.

There are two major problems with a written request system that must be addressed. First, a number of inmates are illiterate, retarded, mentally ill or non-English speaking. The DOC's health staff must develop procedures to provide assistance to these inmates in completing their request forms or provide an alternative way for them to access health services. Second, health staff are cautioned against rigid adherence to the procedure. The purpose of a written request form, after all, is simply to inform them of the inmate's health needs. If other inmates or correctional staff tell a health staff member that an inmate appears ill, it can be both foolish and costly to insist that the inmate complete a written request form. A 1990 death in the King County Jail in Seattle demonstrated the potential folly of this approach.[15]

Regardless of which sick call procedure is used, the important points are to ensure:

- that all inmates have an opportunity to make their health needs known on a daily basis;
- that access is directly controlled by health staff and not by correctional staff (which, in a written request system, includes health staff only picking up the request slips);
- that health staff review all slips received daily and determine the appropriate disposition (e.g., "inmate to be seen immediately" or "scheduled for next sick call" or "referred to dental department"); and
- that inmates are notified of the health unit's response to their requests.

On the latter point, DOCs that have a written request system often use a multiple copy form. One copy is returned to the inmate with the disposition of his/her request noted. This latter step is important. Health staff who fail to notify inmates of the response to their requests frequently are inundated with multiple requests for the same problems from the same inmates. If it is possible to do so without breaching security, it also is a good idea to include a time frame on the disposition copies that are returned to the inmates. This way, they know not only that their requests have been received, but they have some idea of when they can expect to be seen. Generally, inmates are not told the exact date of their appointments outside the institution for security reasons, but can be informed of the time frame for their in-house appointments.

The process described above is essentially triaging requests. *Sick call* occurs when an inmate reports for and receives appropriate care. It must be

held in a clinical setting where adequate equipment and supplies are available. Sick call should be conducted by nurses, physician assistants or other qualified health professionals at least five days per week regardless of the institution's size. Additionally, while the frequency of physician clinics is dependent on institutional size and inmate needs, a prison with 500 or more inmates usually will require a physician to hold clinic at least five times per week.

In general, inmates' requests for non-emergency care should be processed within 24 hours and they should be scheduled for sick call within the next 24 hours. Nurses or physician extenders usually see the patient first to gather additional information, take vital signs and/or provide care within the scope of their licenses. Based on their review, they determine whether the inmate needs to be referred to a physician or another clinician. While it is difficult to state precise guidelines, if an inmate reports to sick call more than twice with the same complaint and has not seen a physician, s/he should be scheduled to do so.[16]

Correctional health practitioners often ask whether they are obligated to see every patient who requests care. Generally, this is the case, although sometimes, common sense dictates otherwise. For example, if a patient was seen recently and submits a request for the same condition, there are times when it is appropriate for the clinician to provide only a written response stating that the medication or therapy will take time and directing the patient to return to clinic only if the condition worsens or does not improve in a specified number of days. Similarly, there are times when a course of treatment has been tried without success and the physician decides that a consultation by a specialist is needed. If there is nothing else the physician can do for the patient in the interim, it is appropriate to notify the inmate that s/he will have to wait. It should be clear that the above examples involve inmates who have been seen previously for the same complaint. It is never appropriate to refuse access to care for an inmate with a new complaint or for one who has not been seen recently.

Another area where practitioners often seek guidance is in the handling of inmates who do not show up for their sick call or clinic appointments. Clearly, inmates have a right both to refuse care and to change their minds. Additionally, a number of medical complaints and illnesses have a self-limiting course and resolve on their own. While inmates must not be punished for refusing care, their failure to show up for scheduled appointments is of concern.

The problem with "no shows" is two-fold: first, they reduce the efficiency of the health unit and second, inmates who need health services may not receive them. In the former case, one solution is to devise a way for inmates to cancel their appointments. If the health staff know which patients will not attend which clinics, other inmates can be scheduled to be seen. To illustrate, the Pontiac Correctional Center in Illinois was experiencing a 40-50 percent "no show" rate for scheduled health appointments. A task force studied the problem by conducting a nine month retrospective review and decided to redesign the medical call pass system. The new pass is a three-part form that allows the inmate to refuse the scheduled appointment (see copy, Appendix F). If s/he refuses, the inmate's copy is returned to the health unit so that the appointment can be canceled and another patient scheduled. Simply by altering the pass system, "no shows" were reduced to about 10 percent.

The other concern with "no shows" is that people who need care are not receiving it. The question is, do health staff have an obligation to follow-up on *all* "no shows" to determine why they did not attend their scheduled appointments? The answer is "no." If an individual is on critical medications or fails to report for monitoring of a chronic disease, health staff should seek out the inmate, determine why the appointment was missed and counsel the inmate to continue the course of treatment prescribed. Similarly, if there is no signed refusal form, segregated inmates who do not show for their appointments should be followed-up to ensure that their access to care was not barred. Otherwise, routine requests from general population inmates who do not show up for their appointments simply can be filed in their medical records.[17] Patients need to assume some responsibility for their own care. It is not practical or necessary for health staff to track down all "no shows."

The discussion on sick call would not be complete without some mention of utilization patterns. Most correctional practitioners are convinced that inmates utilize health services at a rate far exceeding their community counterparts. The few utilization studies that have been published seem to confirm this view.[18] There are a number of reasons why inmate health utilization patterns are so high, only some of which are correctable. For one thing, inmates tend to be sicker than the average citizen as noted elsewhere in this book.[19] Their

lack of prior care and their history of abusing their bodies through poor nutrition, excessive drug and alcohol use etc. mean that some of their increased utilization is justified.

For another, prisons tend to create a general sense of malaise. Inmates are not happy about being confined. Sometimes, their discontent manifests itself in physical complaints. A review of any prison's sick call logs is likely to reveal a substantial number of generalized complaints of subjective pain (e.g., stomach ache, headache, back ache) or bodily disfunction (e.g., diarrhea, constipation, nausea) for which no cause can be determined. Unfortunately, the lack of objective findings in assessing subjective complaints usually involves costly workups and specialty consultant referrals until serious illnesses can be ruled out.

For the most part, these inmates are not faking. They simply do not feel well and they don't know why. Sometimes, the solution is to refer them to a counselor. Often, all they need is someone with whom to talk. Correctional health staff need to recognize that handling inmates with non-specific complaints and illnesses is an important part of their job. Instead of becoming angry or impatient with inmates who are "not sick," they should seek to reassure them that their health needs will be met. Additionally, staff should keep in mind that there are times when the same non-specific subjective complaints are signs of serious illness.

There are, of course, inmates who deliberately abuse the health system and fake symptoms for secondary gains. An individual on lock-down wants to get out of his cell. Another inmate does not want to work in the field. Someone else wants an opportunity to meet a friend housed elsewhere in the prison. Still another inmate may seek a therapeutic diet in the hope of obtaining more palatable food. If health staff suspect that specific patients are overutilizing services, they should try to determine why. Sometimes, the problem lies elsewhere in the prison. A lack of meaningful programs, insufficient exercise, unappetizing food etc. can all result in increased utilization of health services. Vincent M. Nathan wrote an excellent editorial that describes the effect of idleness, boredom and depression on the health unit.[20] His advice is for correctional health professionals to practice social medicine; that is, to try to eliminate the environmental causes that contribute to overutilization and misutilization of health services.[21]

For other repeated abusers of health services (e.g., those who do not want to work or who come to the health unit to meet friends), the problem often can be resolved through scheduling. In other words, these individuals are not denied access, but are told that they will be seen before or after work or otherwise outside the regular clinic hours.

The one group of abusers for whom there is no ready solution is that of individuals on segregated or lock-down status. Since they generally are confined to their cells for up to 23 hours per day, they are strongly motivated to get out for even a brief period of time. Counseling probably will not be successful with this group.[22] Some DOCs have tried to alleviate the problem by providing care in the segregation area rather than in the main clinic. This is acceptable to address routine requests of segregated inmates, provided that a fully-equipped examination area (complete with sink, exam table etc.) that assures visual and auditory privacy exists in the segregated area. In its absence, segregated inmates must be brought to the main clinic. Cellside treatment is not an acceptable substitute.

There is one other reason for increased health service utilization in prisons and it is of our own making. In most DOCs, inmates are required to come to the health unit to receive services and products that are only marginally medically related. An individual who needs dandruff shampoo must come to the health unit to obtain it. Similarly, an inmate whose skin breaks out using the prison-issued soap has to go to the health unit to receive special soap or lotion. Permission not to shave or to receive an extra mattress or a different type of shoe than the regular prison-issued ones -- all must be obtained from health staff. Periodic revisits are required to replace products or to continue permission to deviate from prison rules such as not shaving. In many systems, inmates must come to sick call to receive over-the-counter (OTC) preparations to treat headaches, colds, heartburn or constipation.

Such practices place a tremendous burden on already overloaded health staff. There is no legitimate reason why certain items such as dandruff shampoo, lotion and soap as well as other OTC preparations cannot be made available in the prison commissary. Additionally, DOCs that have tried it (e.g., Florida, Illinois, Texas) have had good success with placing certain OTCs in the housing area so that they are readily accessible to inmates complaining of headaches, colds, constipation or heartburn. Prior to implementing a new OTC distribution system, a written policy statement should be drafted that specifies which OTCs will be available and how they should be distributed and

recorded, and correctional staff should be oriented to the procedure. Making OTCs readily available not only decreases the daily workload for health staff, but also enables inmates to receive prompt relief for their minor complaints.

It is sometimes difficult to convince correctional administrators that inmates safely can be allowed to participate in managing some of their own health care needs. Traditionally, prisons have fostered total dependence of their charges and it is hard to break out of that mold. Nevertheless, it should be tried. If inmates are given the responsibility for some aspects of their health care, this not only can increase their morale and decrease their utilization of health services, but it also can decrease the institution's potential liability. Prison inmates are not children and should not be treated as such. A prison administration that denies inmates any opportunity for self-care has assumed total responsibility for ensuring that all the inmates' health needs are met.

c. Chronic illness monitoring

For the most part, the sick call process is designed to address acute, non-emergency complaints. In addition, each facility needs to have a mechanism in place to monitor individuals with chronic health conditions. By definition, chronic illnesses are either ongoing or recurring. Patients with asthma, heart disease, diabetes, hypertension, AIDS etc. as well as those with certain permanent physical disabilities (e.g., paraplegics) need to be monitored closely to maintain their health status or to slow the progression of their diseases.

The first step in developing an effective program is to identify the number of inmates with specific chronic conditions. While this seems obvious, there are still a number of DOCs where the health staff cannot state precisely how many inmates have specific medical conditions.[23] Each DOC should have clinical protocols for chronic conditions that provide guidance to practitioners in managing their patients' care. An individualized treatment plan must be developed for each of these patients that includes instructions regarding medications, special therapies (e.g., physical therapy, respiratory therapy), exercise, diet, the type and frequency of laboratory and other diagnostic testing, and the frequency of follow-up for reevaluation of the patient's condition and adjustment of the treatment plan as needed.[24]

Establishing chronic clinics where such patients are scheduled for routine revisits to the health unit can help to ensure that they receive needed care. For these patients, it is imperative that health staff take an aggressive approach. Owing to the seriousness of their conditions and the potential for negative outcomes, patients with chronic conditions should not be left to seek care on their own. Once identified and included in a regular "return to clinic" system, though, they can be taught to manage certain aspects of their care. Counseling and self-care instruction by clinicians, health educators or dietitians can be of great assistance to these inmates both within the prison and upon their return to the community. For example, diabetics can be taught to administer their own insulin, to monitor their own glucose and to select an appropriate diet. While some of these activities still must be supervised by health staff for security reasons, inmates are provided with valuable information they can use for the rest of their lives.

Teaching inmates to assume some responsibility for managing their chronic conditions also can improve their compliance with prescribed treatment regimens while incarcerated. At the Oregon State Penitentiary, a monitoring and evaluation study of diabetes and hypertension revealed only sporadic patient compliance. It was determined that inmates' lack of knowledge about their diseases and loss of control over aspects of their own care were contributing to the problem. As a consequence, nursing clinics were established to teach diabetics and hypertensives about their diseases and to promote self-care. Catherine M. Knox, administrator of health services for the Oregon DOC, described the program as follows:

> *Diabetic patients were given responsibility for diet selection, and for the collection of data to track blood glucose levels, medication types and dosages. They also scheduled their own blood glucose monitoring. Compliance with prescribed treatment has increased 40% since the program was initiated. A similar increase was noted with hypertension patients in compliance with medication, diet, and blood pressure monitoring.*
>
> *After the patients receive education from the clinic nurse about diabetes or hypertension, they are given responsibility for recording in a notebook their own data base and noting any deviations from normal values. This process allows the patients to correlate any changes in blood pressure or blood glucose with*

modifications in diet, exercise and/or medication. These changes and progress are discussed with the health care staff managing the chronic disease clinic at regular intervals.

Providing reasonable opportunities for patients to participate in self-care and permitting them to control scheduling of monitoring procedures better prepares them to manage their conditions upon discharge from the correctional institution. When knowledge and control of chronic health care problems are returned to the patient, compliance with prescribed treatment regimes increases. (Personal communication, March 1, 1991)

Sometimes, correctional practitioners complain that in spite of their best efforts, inmates with chronic conditions are continually non-compliant with their care instructions. This happens to community providers as well, of course, but the difference is that correctional health personnel cannot terminate their provider/patient relationships if someone refuses to cooperate with the prescribed treatment regimen. Correctional practitioners may be tempted to restrict certain rights and privileges for their recalcitrant patients such as prohibiting an asthmatic from purchasing cigarettes or a diabetic from purchasing candy or other inappropriate food items. Except in a controlled medical environment such as an infirmary or a hospital, this is not practical if such privileges are extended to other inmates. The only recourse is for the clinician to continue to counsel such patients about the need to follow the prescribed treatment and to document the counseling in the patients' charts. The patients then are responsible for any deterioration in their health conditions attributable to their failure to follow care instructions.

d. Medication distribution

Medication must be distributed every day, up to four times a day, 365 days per year. Given the number of inmates with health problems, some of whom have multiple conditions, the number of medications passed annually in most prisons is staggering. In some DOCs, medications are distributed from a central area. In others, all medications are brought to inmates in their housing areas. Still others use a combination approach (e.g., general population inmates come to a central "pill window" and medications are brought to inmates in segregation). It does not matter which system is used as long as the following precepts are observed:

- Medications are dispensed by individuals licensed to do so;
- Each prescription is labeled appropriately in accordance with applicable regulations, and at a minimum, has the following information: date and pharmacy prescription number; patient name; name of the drug, strength, and amount dispensed; directions to the patient for use; prescriber name; and any other pertinent information;
- Medications are passed by health personnel who have been trained (e.g., medication aides) or licensed (e.g., LPN or RN) to do so;
- Administration of medications or their refusal is recorded on individual patient logs or computer files; and
- For security reasons, patients on abusable medications are watched to ensure that the medications are taken and not hoarded.

There are ways to cut down on the number and types of medications distributed. Establishing a pharmacy and therapeutics committee can be of great assistance in limiting the types of medications that can be ordered by clinicians as well as monitoring their prescribing practices. Periodic studies by such a committee can help to ensure that medications are used for legitimate medical purposes and not for punishment or inmate control. Additionally, the prescribing practices of individual practitioners can be reviewed. Such a committee also can control the use of certain medications by requiring the clinician to obtain special permission to order them or by prohibiting them altogether (such as minor tranquilizers).

Another technique that has worked well in some DOCs is to move to a system of *b.i.d.* (i.e., twice a day) distribution. While some medications (e.g., certain antibiotics) still must be distributed three or four times a day as ordered, many categories of drugs are available in *b.i.d.* preparations. This step alone can represent tremendous savings in staff time.

Removing certain over-the-counter preparations from the medication distribution system and making them available elsewhere has been addressed already, but there are also a number of prescription medications that need not be distributed one at a time. Some DOCs (e.g., the Federal Bureau of Prisons, Idaho, Texas, Illinois, Florida) have had good success with a "keep on the person" (KOP) medication program. DOCs interested in initiating a KOP medication program should develop a written policy and procedure and orient health staff, inmates and correctional staff to its use prior to implementation. At a minimum, the policy should specify:

- *which medications may be given in multiple doses and which may not (e.g., psychotropic medications, control drugs and any abusable preparations should always be administered in single doses);*
- *...the types of inmates who may be given multiple doses (e.g., those who have been compliant in taking their medications in the past);*
- *...the reasons an individual may be withdrawn from the keep-on-the-person medication program (e.g., non-compliant, gave or sold medications to someone else);*
- *...the form of medications allowed to be issued in multiple doses (e.g., tablets only or tablets and ointments but no liquid medications);*
- *...the procedures for renewal of the prescription and for disposing of any unused portion; and*
- *...the maximum number of allowable preparations that may be in the possession of a single inmate at one time (e.g., no more than 30 pills of a single type and no more than three prescriptions).*

  This latter practice is much more advisable than using a time period (e.g., a week's supply or a month's supply) since with some medications, a month's supply would represent an inordinate amount of pills in someone's possession (Anno, 1990).

2. Specialty Care

Every DOC, no matter how small, is likely to have some inmates who require the services of medical specialists. The decision as to whether specialty care is offered on-site at every prison, only at specific prisons, only in the community, or some on-site and some off-site, is dependent on a number of factors, the most important of which is patient need. The number of patients in the system requiring each type of specialty care will dictate which specialty services should be provided within the DOC and at which institutions, and which should be provided at community facilities.

Assuming the availability of specialists in the community, their willingness to treat inmates and the existence of appropriate specialty equipment at the prison, it is preferable to conduct specialty clinics on-site. This avoids the added security risk of transporting inmates outside the institution and the added costs of custody time and transportation expenses. Obviously, there are times, though, that certain specialty services are not available locally or that it is not cost-efficient to duplicate specialty services (including expensive diagnostic equipment) on-site.

Regardless of whether specialty care is provided on-site, off-site or both, it is paramount that arrangements for such services be made in advance of need. Each DOC's health services policy manual should define clearly the levels of care available at each prison in the system and specify where additional services are provided. Procedures for making specialty referrals and arranging for transportation when needed should be included.

When specialty services are provided outside the DOC, it is a good idea to use a consultant form that tells the specialist why the referral was made and has space for the consultant to note his/her findings and recommendations. This form must be transferred and returned with the inmate, and then forwarded to the referring physician. Such a form also can be used for specialty consults that occur on-site. Alternatively, the specialist should record his/her findings and recommendations in the regular progress notes section of the patient's chart.

Specialists that work for the DOC -- whether as full-time or part-time employees or under personal contracts -- need to be oriented to the correctional

environment and to the institution's security regulations and health services' policies and procedures. Additionally, each on-site specialist should be required to provide evidence of continued licensure.

3. Inpatient Care

At any given time, a certain number of a DOC's inmates require inpatient services for medical conditions. Different DOCs use different estimates of the number of medical infirmary beds required in the system that generally range from one-half percent to one percent of the population -- i.e., five to ten medical infirmary beds per 1,000 inmates. Additionally, every DOC needs to establish arrangements for providing inpatient hospitalization for conditions that cannot be treated adequately in the system. Guidelines for both types of inpatient services are discussed below.

a. In-house inpatient services

Part of the difference in DOCs' estimates of the number of medical beds required in-house may be attributable to differences in patient needs, but some undoubtedly is owing to differences in the definition and utilization of infirmary services. For example, in some DOCs, inmates with broken legs, females in their last trimester of pregnancy or elderly inmates may be housed in the infirmary. In others, inmates with these same conditions are housed in general population and in some DOCs, they reside in special medical housing.

The first step in determining how many in-house inpatient beds are needed in the DOC is to separate patients into categories of care based on the types of inpatient services required. There are essentially three levels of in-house medical beds: sheltered housing, extended care and skilled nursing care. A fourth type, often called medical observation beds, is designed for short-term use only (e.g., less than 24 hours) and should be used only when health staff are present in the area.

Sheltered housing is appropriate for inmates who may need a more protective environment, but who do not require 24 hour per day nursing care. In most DOCs using it, sheltered housing is a regular housing area designated for a special purpose. It often is adjacent to the health services unit, but is not a special facility. The types of medical patients for whom sheltered housing may be appropriate include individuals who may have difficulty ambulating (e.g., some elderly, some amputees, paraplegics), those who may be convalescing from a non-serious condition (e.g., broken bones, colds), and those who may require more frequent ambulatory services (e.g., pregnant inmates, chronic disease patients). In other words, these are individuals who might be restricted in some of their activities, but who would be cared for at home or would care for themselves in the "free world."

Patients needing extended care are those that would be in a nursing home or hospice on the outside. They include individuals who are terminally ill (e.g., AIDS patients, cancer patients), those suffering from problems associated with aging (e.g., Alzheimer's disease, incontinence), some mobility impaired individuals and those who may be in the latter stages of chronic diseases (e.g., certain heart disease patients, those with chronic obstructive pulmonary conditions). These patients generally need daily medications and/or therapy and assistance in performing basic functions such as washing, dressing, eating or ambulating.

The third level of in-house medical beds is for patients requiring skilled nursing services (e.g., those on IV therapy, burn patients, post-surgical patients), but not hospitalization. These individuals also need daily nursing care, but usually at a higher level (i.e., RN versus LPN) and for a shorter duration than the extended care patients.

Patients needing extended care or skilled nursing services must be treated in an infirmary setting, which NCCHC (1987:36) defines as "...an area within the confinement facility accommodating two or more inmates for a period of 24 hours or more, expressly set up and operated for the purpose of providing skilled nursing care for persons who are not in need of hospitalization." Written policies and procedures guide the operation of the infirmary and cover the following elements at a minimum:[25]

- definition of the scope of services provided;
- a physician who is on-call 24 hours per day and who sees patients as required by the severity of their illnesses;
- daily supervision by a registered nurse;
- health personnel on duty 24 hours per day, seven days per week, who make rounds a minimum of once per shift and more often as required by patients' needs and physicians' orders;

- patients within sight or hearing of a health staff member (e.g., call lights, buzzer system);
- written nursing care procedures;
- complete inpatient records including admission and discharge notes; and
- admission to and discharge from the infirmary only on the order of a physician or other authorized health professional.

The latter point bears special mention. Correctional administrators, especially in crowded institutions, sometimes are tempted to use the infirmary for non-medical housing. This is not permissible. It violates the principle of medical autonomy and can be extremely disruptive to the smooth operation of the infirmary. More important, it can result in the denial of infirmary services to patients in need, owing to a lack of available beds. Unlike sheltered housing beds (which tend to be part of the regular prison housing and more or less permanent placements for inmates), medical inpatient beds are for temporary use and should not be included in the prison's rated capacity. In larger DOCs, if there is a separate extended care facility where patients are placed permanently, it would be an exception to the rule, but in general, infirmary beds should be used only to house inmates until their medical conditions improve sufficiently to warrant discharge or deteriorate to the point that hospitalization becomes necessary. These are clinical decisions that cannot be ignored or overruled.

For planning purposes, it is important for health staff at each prison with medical inpatient beds to keep utilization data (e.g., daily number of patients, their conditions, lengths of stay). Such information is crucial in trying to determine whether the DOC has a sufficient number of in-house beds to meet the demand. If utilization data consistently show that existing medical beds are not filled, a quality assurance study should be conducted. While it is possible that the system has over- built its medical beds by overestimating patient need, it also is possible that infirmary beds are underutilized compared with patient need. Some practitioners are reluctant to place their patients in the infirmary, since that entails additional work and more extensive charting. A quality assurance audit that focuses on inmates with acute and chronic conditions should help to determine whether inpatient beds are overbuilt or underutilized.

b. Hospitalization

The advantages of a DOC operating its own hospital are that it can be built and staffed to ensure maximum security,[26] and that it can be operated according to the DOCs own admission and discharge criteria -- unencumbered by diagnostic-related groups (DRGs) and length of stay (LOS) restrictions that regulate admission and discharge in community hospitals. Any health administrator who has been notified late on a Friday afternoon of the imminent discharge of an inmate/patient can appreciate the latter advantage and correctional administrators can appreciate the former. The disadvantage of a DOC operating its own hospital is primarily one of cost. It is inordinately expensive to staff, equip and maintain a hospital that meets community standards. Additionally, it is difficult to attract qualified health professionals to work in remote locations.[27]

Only a handful of correctional systems are large enough to justify operating their own hospitals and even then, community facilities sometimes are needed to avoid delays in care or to provide sophisticated services. Regardless of where the care is provided, every DOC needs to make arrangements for hospital services in advance of need. Any hospital utilized for inmates' inpatient care must meet the criteria for licensure and other regulations governing hospitals in the state and should be accredited by a state agency or the JCAHO.

Also, the DOC should have a written agreement with each hospital utilized. Its health services policy manual should specify which hospitals are to be used for each prison as well as the procedures for arranging transportation and hospital admission. It is imperative that a hospital discharge summary accompany the patient upon his/her return to the prison system. This form should state not only what care was provided, but should include instructions for follow-up care as well. Many DOCs have found that designating a "discharge coordinator" to work with hospital personnel helps to ensure that the patient is returned to an appropriate medical environment within the prison system.

4. Emergency Care

Every prison, no matter how small, must have a plan for responding to medical emergencies. By definition, emergencies are unforeseen occurrences that require immediate action. While staff cannot know when a medical emergency will occur, they must know how to respond appropriately when the occasion arises.

First and foremost, each prison must have a written plan for medical emergencies that:

- designates one or more hospital emergency departments or trauma centers to which patients will be transferred;
- provides the name and number of a physician who is on-call 24 hours per day;
- specifies the arrangements, including security procedures, for emergency evacuation of the inmate from the prison; and
- identifies the mode(s) of transportation that will be used.

Additionally, owing to the remote location of most prisons, it is imperative that certain in-house capabilities exist to respond to medical emergencies. Since they are likely to be the first responders, all correctional staff who work with inmates must be currently trained in cardio-pulmonary resuscitation (CPR). All but the smallest prisons should have medical staff on duty 24 hours per day, 365 days per year. Health staff also should be CPR trained and where appropriate, designated physicians and other practitioners should have training in advanced life support measures. Further, it is excellent policy for the DOC to require quarterly drills of simulated medical emergencies at each institution. These drills should be critiqued and each shift should participate in them at least once a year. Moreover, each institution should have a mock disaster drill annually that is designed with the cooperation of community resources.[28]

Assuming the availability of appropriately trained health staff, the prison's emergency room should contain the following basic equipment at a minimum:

- A crash cart containing the necessary emergency supplies and equipment to treat and stabilize patients prior to transfer (which should be kept fully stocked and should be inventoried after each use);
- a portable emergency medication box (which is kept stocked, locked and inventoried after each use);
- emergency stretchers;
- portable oxygen containers;
- IV stands and supplies; and
- a defibrillator/monitor.[29]

One of the biggest problems facing prison staff in responding to medical emergencies is often the lack of readily available transportation. Few prisons are located in an area where community emergency medical systems are able to provide emergency medical technicians (EMTs) and/or ambulances within a reasonable response time (e.g., fifteen minutes). Consequently, many prisons will need to employ their own EMTs and operate their own ambulances. Where this decision is made, the statewide HSD must ensure that community standards are met regarding EMT training, and equipping and maintaining the DOC's ambulances.

C. The Mental Health Program

Published studies estimating the prevalence of mental illness in state prisons have reported anywhere from one percent to 77.5 percent of inmates afflicted, although much of the variability is owing to differences in defining mental illness.[30] More controlled studies tend to report a prevalence of serious psychiatric illness at five to seven percent of the inmate population and an additional 15 to 20 percent of inmates who need psychiatric services at some point during their incarceration.[31] These latter rates generally do not include personality disorders and substance abusers for whom some counseling services should be available. Additionally, a smaller percentage of prison inmates are classified as mentally retarded and require certain support services from the mental health program. A survey of state and federal correctional systems by McCarthy (1985) showed that about 2.5 percent of the total

inmate population was classified as mentally retarded, but other studies suggest that 10 percent may be a more accurate figure.[32] Clearly, there is a need for a strong mental health component in DOCs' health services divisions.

Much has been written about the deinstitutionalization of the mentally ill and its resultant impact on corrections.[33] Additionally, there are numerous articles and books that address the management of specific mentally disordered offenders (e.g., suicidal inmates, sex offenders, self-mutilators), some of which are reviewed in Chapter VIII of this manual. This section seeks only to describe certain of the system components that should be in place to operate an effective mental health program.

In Chapter V, it was stated that the preference was for a unified health system -- i.e., one where medical, dental and mental health services were organized under a single health authority at both the unit and the central office levels. In DOCs where this is not the case, strong measures must be taken to ensure effective coordination between the medical and mental health programs to enhance continuity of care.

1. Intake

Mental health questions must be included as part of the receiving screening and follow-up health history described above under the medical program. These procedures help to identify patients with gross mental abnormalities who are in need of immediate care and treatment. Additionally, each DOC needs a separate mental health screening and evaluation process for all new admissions that is designed to identify level of functioning and to uncover less obvious mental conditions. The NCCHC's standards (1987: 25) state that:

> *The post admission mental health evaluation should include at a minimum:*
>
> *(a) a structured interview by a mental health worker in which inquiries into the items listed...are made. (History of psychiatric hospitalization and outpatient treatment; current psychotropic medication; suicidal ideation and history of suicidal behavior; drug and alcohol usage; history of sex offenses; history of behavior suggestive of intermittent explosive disorder; special education placement; history of cerebral trauma or seizures; and emotional response to incarceration.)*
>
> *(b) testing of intelligence for mental retardation. It is recommended that inmates identified as possibly retarded on group tests of intelligence or brief intelligence screening instruments be further evaluated by a comprehensive, individually administered instrument such as the Wechsler Adult Intelligence Scale (WAIS-R).*

Mental health evaluations need not be conducted by psychiatrists or clinical psychologists, but these professionals should be intimately involved in developing the screening instruments, in training mental health workers in the application of those instruments, and in drafting guidelines for referral of patients in need of subsequent services.[34] Additionally, psychiatrists and clinical psychologists are needed to provide in-depth workups and to develop appropriate treatment plans. Other mental health professionals including master's level psychologists, counselors, social workers and psychometrists should be employed to carry out other aspects of the mental health program.

The results of the post-admission evaluation (which is performed on intake into the DOC) help to determine appropriate housing and program assignments for mentally disordered offenders. Each individual identified as disordered needs a treatment plan that specifies the frequency and extent of follow-up care as well as the level of services (e.g., inpatient, outpatient, sheltered housing).

2. Crisis Intervention

Crisis intervention is defined as short-term care for acute mental distress. It is, in a sense, emergency care in that it addresses unforeseen occurrences that require an immediate response. It differs from emergency care in that crisis intervention services are designed to meet a wider range of need. Some inmates may have a true psychiatric emergency (e.g., acute psychotic break, major depression, suicide attempt), but others are experiencing a less serious, although traumatic, emotional state such as an adjustment reaction to incarceration, the aftermath of homosexual rape, or grief following the loss of a loved one. These latter individuals need short-term supportive counseling while the former need to be referred to appropriate staff and facilities for care.

Each prison in the DOC must have arrangements for handling both types of crises. Procedures for addressing psychiatric emergencies should include the components noted in the discussion in the prior section on medical emergencies. For less serious conditions, care must be taken in assessing whether the crisis was precipitated by a special situation or was the result of an underlying mental illness that will require future services. If the former, it is suggested that such individuals not be entered on the regular mental health caseload. More than one inmate has had the experience of seeking mental health services in a time of special need, only to find that the label "mentally ill" followed him/her throughout confinement. Once labeled, these inmates often experience problems in qualifying for furloughs, special programs and parole.

Crisis intervention care need not rely solely on the services of mental health clinicians. Some DOC's have had good success with utilizing crisis intervention teams comprised of both mental health professionals and other trained staff members. Anthony T. Schaab, PhD, who serves as the chief of mental health services for the Illinois DOC provided the following description of crisis intervention teams in Illinois prisons:

> *Each institution is required to maintain a crisis intervention team with a member on-site 24 hours per day. The team is led by the institution's psychologist or clinical social worker and typically includes nurses, correctional counselors, security command staff and correctional officers. All members receive 16 hours of initial training through the DOC's training academy. The training is provided by mental health professionals and includes recognition of symptoms of mental illness and basic crisis intervention skills. Each institution's crisis team leader provides two hours of training quarterly to all members. The on-site crisis team member is called on in any situation in which self-harm has occurred or has been threatened or mental illness is suspected.*
>
> *Since the initiation of the team concept in Illinois, two trends have emerged that we believe are largely attributable to the growing sophistication of the teams. In the first six years of their existence, while the inmate population increased 33 percent, the number of suicides decreased from six-to-eight per year to three per year. Simultaneously, the number of inmates placed on a formal suicide watch status decreased by some 25 percent. At this time, the age-adjusted suicide rate for the DOC is at or below the rate in the free community. Anecdotal information from the institutions indicates that a large percentage of crisis calls are resolved by team members without the need to resort to formal suicide watches.* (Personal communication, January 15, 1991)

3. Outpatient Treatment

Unless the management of the mentally ill is confined to special institutions, every prison needs the capability of providing not only crisis intervention services but also basic ongoing mental health services commensurate with outpatient care in the community. Such services include individual counseling, group counseling, psychiatric and psychological consultations, medication monitoring and periodic reevaluation of the effectiveness of the treatment modality employed and adjustment of the treatment regimen as needed.

For the most part, supportive counseling is likely to be the service most utilized, since individuals with more serious psychiatric disorders often do not function well when placed in the general population. On the other hand, a substantial proportion of the inmate population can benefit from the ready availability of mental health counselors. As noted in the section on sick call, a great many inmates simply need someone with whom to talk. They do not meet the classic definition of psychiatric illness or psychological impairment, but they are unhappy with their lives and depressed by their surroundings. Supportive counseling programs can do much to alleviate inmates' anxiety, assist in their adjustment to prison life and help them to plan for the future. Such programs also reduce utilization of the medical program and contribute to the well-being of the institution.

In prisons, a strong argument can be made for lowering the threshold for mental health care at every level.[35] If inmates know they can talk to someone when they need to, they are less likely to suffer from psychosomatic symptoms or to resort to more dramatic ways of gaining attention (e.g., suicide gestures, self-mutilation). When compared with the cost of other types of medical and mental health care, supportive counseling programs are not

expensive. All that is required usually is appropriately trained staff (e.g., bachelor's and master's level psychologists supervised by a clinical psychologist) and a quiet, private area in which to talk.

4. Inpatient Services[36]

Unlike the medical program, inpatient psychiatric services tend to be provided by the DOC itself rather than by state or community hospitals. Often, this is by default rather than by design owing to a lack of available acute psychiatric beds in the community or to the refusal of community facilities to treat offenders. This can be to the DOCs advantage, though. Part of the difficulty in utilizing "free world" psychiatric beds is that most hospitals use "achieved maximum hospital benefit" as their primary criterion for patient discharge. If the same discharge criterion is used in prison, it results in people who are still seriously mentally ill being housed in the cell-blocks. Not only does this present management problems for correctional administrators, but it also increases the cost of care by precipitating a cycle of hospitalization, discharge, destabilization and rehospitalization of psychiatric patients.

In prisons, a more rational criterion for discharge from acute care is "current level of functioning." Patients can be maintained in DOC-operated psychiatric facilities as long as it is the best placement for them, without regard to community restrictions defining admission, length of stay and discharge criteria.

The primary disadvantage of DOC-operated psychiatric facilities is that they are expensive to build, equip, staff and maintain according to community guidelines. They must meet all of the elements described in the section on infirmary care and some of the requirements for hospitals as well. In determining the number of acute psychiatric beds that will be needed for a DOC, many experts estimate it at about one percent of the total DOC population. This figure has proven fairly accurate in systems such as Illinois, Oklahoma and Texas.

In addition to acute psychiatric beds, a certain portion of the prison population needs what can be termed "intermediate care." For the most part, these individuals represent the chronically mentally ill. They are stabilized and not in need of acute hospitalization. On the other hand, they are not ready to be discharged to the general population. To put it into some perspective, individuals in the community who require intermediate care would be found in group homes, day hospitals and Fairweather lodges.

In prisons, intermediate care beds can be located in existing units. The need is not for a special facility, but for special programs. A higher mental health staff to inmate ratio is required in prisons offering intermediate care, over and above the ratio needed to provide crisis intervention and basic outpatient services. Intermediate care patients require a protective environment, the availability of supportive counseling, and monitoring to ensure that they are taking their medications, eating appropriately etc -- in essence, case management.[37] The thrust of intermediate care should be to acclimate individuals so that they can function in a regular cell-block, although few of the chronically mentally ill do well in general population. For many of them, the absence of a sheltered environment precipitates another acute episode and initiates the "revolving door" treatment cycle all over again.[38]

5. Special Issues: Seclusion, Restraint and Forced Psychotropic Medication

In every prison, there are times when mental health emergencies, as a result of disorganized or dangerous behavior on the part of the mentally ill or mentally retarded individual, justify the use of seclusion, restraint or forced psychotropic medication. It is imperative that every DOC have written policies and procedures in place that delineate the circumstances under which seclusion, restraint or forced psychotropic medication may be used to control an inmate's behavior. State laws and regulations have been developed to govern these situations and they must be strictly adhered to in the use of these extreme treatment modalities.

In every DOC, the director of mental health services should be aware of all state laws and regulations governing seclusion, restraint and forced psychotropic medications. Additionally, s/he should research the clinical issues surrounding their use and be cognizant of the recommendations of national professional associations including the American Public Health Association, the National Commission on Correctional Health Care, the American Psychiatric Association and the American Psychological Association. The American Psychiatric Association has published various task force reports that address these issues.[39]

Based on the results of researching both the legal and clinical issues, written policies and

procedures are needed for all three treatment modalities that cover the following elements at a minimum:

- prohibiting the use of these modalities for punishment;
- requiring their authorization only by a physician or another clinician where specified by law;
- defining the clinical criteria for use (e.g., patient is dangerous to self or others);
- limiting the time and frequency of use of these extreme measures;
- specifying staff responsibilities for monitoring patients, reevaluating their progress and fully documenting such encounters in the patients' medical records; and
- training relevant staff to ensure that they are familiar with all aspects of such policies and procedures.

Additionally, the DOC's statewide mental health director should require that staff at each prison maintain statistics on the frequency of use of each of these procedures. This will facilitate conducting quality assurance audits on the systemwide utilization of seclusion, restraints and forced psychotropic medications. Such studies can help to determine whether the DOC's procedures are adequate to protect patients' rights and whether staff are using them appropriately.

D. The Dental Program

Early studies of prisoners' health care needs consistently found a high proportion of inmates requiring dental services -- sometimes 90 percent or greater.[40] More recent studies have confirmed that inmates arrive at prison with extensive requirements for dental care. In their study of dental treatment needs of recently incarcerated inmates in Texas, Barnes *et al.* (1988) reported that only about 1.5 percent of the 637 inmates examined needed no care.

While the literature is not extensive, there are a few publications that address the development of a correctional dental program[41] or specific issues such as legal considerations,[42] screening options,[43] staffing alternatives[44] and prioritizing treatment needs.[45] Additionally, the American Dental Association (ADA) offers numerous publications, forms, and audio-visual materials that can assist correctional dentists in their care and treatment programs, continuing education offerings for staff, infection control measures, and dental education efforts for inmates.[46] In this section, some of the basic care components of a correctional dental program are presented.

1. Intake

The basic goals of the dental program should include relief of pain, elimination of infection and disease, and restoration of function at a minimum.[47] In order to achieve these goals in a timely fashion, patients' dental needs must be identified upon their admission to the DOC. Dental questions should be included in the receiving screening and health history forms discussed earlier under the medical program. Additionally, every inmate should receive a dental screening, and an examination by a licensed dentist. NCCHC's standards state that dental screening must occur within the first seven days of an inmate's incarceration and an examination within the first month.[48] This latter requirement is consistent with APHA's recommendations.[49] In many DOCs, though, the dental screening and examination are both conducted at the reception center as part of the intake process for new admissions.

Dental screening can be performed by dentists or by other health personnel as directed by dentists. Its purpose is to identify gross abnormalities requiring immediate care that cannot wait for regularly scheduled sick call. This is usually a good time to provide oral hygiene instruction and dental health education, since many of inmates' dental needs are attributable to a lack of self-care.

The dental examination is more extensive than the screening and requires the professional expertise of licensed dentists. It includes reviewing the patient's medical and dental histories and current complaints, examining the oral cavity to chart teeth and review the status of tissues and bone structure, and obtaining full-mouth x-rays. Based on the results of the dental exam, treatment plans should be developed for each patient in accordance with a written priority system.[50]

2. Basic Dental Care

All except the very smallest prisons need the capability of providing basic dental services on-site including extractions, surface restorations, prostheses, prophylaxis and other preventive measures. The practice of modern dentistry necessitates not only trained staff (dentists, hygienists, dental assistants), but also dedicated dental space, and specialized equipment,[51] instruments and supplies. Owing to the extent of inmates' dental needs, most prisons will find it is more cost-effective to duplicate basic services in-house at each prison rather than to transport inmates to other prisons or community facilities.

The intake dental examinations identify patients' needs on admission to the DOC, but cannot foretell deterioration of dental conditions over time or address dental emergencies. Inclusion of dental care in whatever system the DOC has adopted for inmates to request non-emergency services (e.g., written sick call system, walk-in) is imperative. If a written sick call system is used, health staff triaging those requests must refer all dental complaints to the dental staff for response. The latter are responsible for reviewing the requests and setting up appointments for inmates to be seen according to the system established for prioritizing dental needs.

T. H. Heid, DDS, who serves as the director of dental services for the Texas prison system, suggests that basic dental care can be categorized as follows:

- *Emergency/Urgent Care. Individuals requiring treatment for the relief of acute oral and maxillofacial conditions characterized by trauma, infection, pain, swelling, or bleeding which are likely to remain acute or worsen without intervention.*

- *Interceptive Care. Individuals requiring early treatment for the control of extensive, subacute dental or oral pathosis and/or requiring basic education in oral self-care.*

- *Corrective Care. Individuals requiring treatment for chronic dental and oral pathosis and for the restoration of essential function. (This level of care should include restoring carious teeth, extractions, the long term management of periodontal disease, and endodontic and prosthodontic procedures needed to retain or restore essential masticatory function.)*

- *Elective care. Individuals who have none of the treatment needs specified above.*

The above, of course, is only a basis for a system of prioritizing dental needs and for identifying those specific treatment procedures employed by the institution to meet program goals. It should not be overlooked that providing basic education in oral self-care should have a high priority. In fact, documented inmate compliance with self-care instructions should be a prerequisite (not a barrier) to receiving any corrective dental care. (Personal communication, January 23, 1991)

Doctor Heid's last point deserves additional discussion. Most dentists would agree that regular flossing is the best way to avoid serious periodontal disease, but many DOCs prohibit the use of dental floss for security reasons. Dental floss is quite strong and has been used by inmates to saw through bars or as a weapon. There are ways to accommodate both the dental need and the security concern, however. One solution is to issue the floss daily and supervise inmates to ensure that it is used and disposed of properly. A less labor-intensive solution is used in the Texas system where inmates are issued plastic picks that have about an inch of floss attached to a small bow. The amount of floss is too small to cause any security concerns, yet is sufficient to allow inmates to practice good oral hygiene.

3. Specialty Care

In addition to the dental care provided on-site at each prison, arrangements must be made to obtain specialty services such as periodontics, endodontics and oral surgery when needed. Some DOCs may be large enough to support these specialties in some of their institutions, but most will find it more advantageous to utilize community resources. Because some dental care can be considered elective, each DOC should have carefully thought-out protocols that specify the types of dental specialty services that will be provided. As with all specialty care, contractual terms and procedural arrangements

for appointments, transportation, security etc. should be made in advance of need.

4. Emergency Care

True dental emergencies are rare. With the exception of facial fractures, uncontrolled bleeding, and infections not responsive to antibiotic therapy, there are few instances when immediate referral for dental care is indicated. Other conditions such as toothaches, abscesses and post-extraction complications may be painful, but they usually do not constitute emergencies. They are better classified as urgent conditions. Even a fractured tooth more often requires urgent rather than emergency care, although one involving the dental pulp or an avulsed tooth may require prompt attention by a dentist to better ensure that it can be retained.

A true dental emergency (e.g., fractured jaw) -- especially if it occurs "after hours" -- requires that the patient be transported to a hospital emergency department for care. Dental emergencies should be included in the protocols governing emergency services as discussed under the medical program. On the other hand, urgent dental conditions that occur after regular dental hours can be handled by a nurse or a physician extender with a back-up dentist or physician on-call to prescribe medication as needed. The DOC's dental director should develop protocols to guide non-dental health staff in managing urgent conditions until the patient can be seen at the next scheduled dental clinic.[52]

E. Other Services

There are a number of ancillary health services (e.g., pharmacy, laboratory, radiology, dietetics) and special therapies (e.g., respiratory therapy, physical therapy, occupational therapy) that support one or more of the three basic health programs noted above. Additionally, custody staff have an important role to play in ensuring that each prison's health unit operates smoothly. General guidelines governing ancillary services and custody staff's role in the health program are discussed below.

1. Ancillary Services

Only those prisons with a special health mission (e.g., inpatient units) are likely to have a full range of ancillary services on-site. In most DOCs, it is more cost-effective to regionalize or centralize ancillary services and special therapies, and in the smallest DOCs, virtually everything beyond basic care is purchased from community providers. Owing to differences in the utilization and organization of ancillary services and therapies among various DOCs, it is difficult to state precisely what elements should be in place at each facility. There are, however, some general guidelines that should be followed:

- Each DOC's health services policy manual should specify for each prison what ancillary services and special therapies are available on-site, and each on-site service should have its own procedural manual.

- All staff (whether full-time, part-time or contractual) used on-site for special services must be appropriately licensed, certified or registered.

- State and federal regulations governing special services must be followed (e.g., safety inspections for radiological equipment, DEA guidelines for pharmacy operations, disposing of infectious waste for laboratories).

- For any service or therapy not provided on-site, the DOC's health policy manual must indicate for each prison where such services and therapies are available, and must include procedural instructions for staff in arranging scheduling, transportation etc.

More specific guidance in operating and managing ancillary services and special therapies is available from various health professional associations representing those services (e.g., American Dietetic Association, American Pharmaceutical Association) and from national health standard-setting bodies such as APHA, JCAHO and NCCHC.

2. Custody Support

Every prison's health services unit requires support from custody staff in order to operate efficiently. The usual roles for custody staff are to provide security within the health unit itself, to escort patients to and from the health unit, and to transport patients to scheduled appointments with community health providers. In some prisons,

security regulations also require that health staff be escorted anywhere in the prison except within the health unit itself. The need for such a policy should be scrutinized carefully, since it has extensive staffing implications for the custody program. Failure to allocate sufficient correctional officers (COs) to carry out such a policy can be very costly in terms of both wasting clinical time and increasing the DOC's potential liability. Lack of a sufficient number of COs to provide security is not a defense for failing to deliver medications on a timely basis or delaying the care or treatment of patients.

Aside from the basic roles of providing security, escorting patients in-house (and health staff where required) and transporting patients to outside health facilities, correctional staff should not be involved in the routine operations of the health unit. They should not pick up medical request slips, take health histories and vital signs, schedule health appointments, file health records, serve as orderlies or provide any patient care or treatment. Even though a number of these activities do not require a qualified health professional to perform them, the potential for role conflict is too great to assign such tasks to COs. Further, correctional staff assigned to the health unit to provide security must be instructed that any information they obtain about patients' health conditions must be kept confidential.

There is one potential exception to the general rule regarding custody staff's role in health programs. Inpatient mental health units in some DOCs include correctional staff on their treatment teams. For example, the Texas Department of Criminal Justice (TDCJ) uses COs as psychiatric aides in its inpatient mental health facilities and as rehabilitation aides in its special programs for the retarded. There is some logic to utilizing correctional staff as paraprofessionals in prison mental health units. COs assigned to special mental health units typically spend more time observing and interacting with the residents than do clinical staff. Their observations are invaluable in determining patients' progress. Moreover, as Coleman (1988: 684) notes: "Several studies have found that paraprofessionals or lay individuals often perform as well, relative to clinical outcome measures, as professionals and that they sometimes perform more effectively."

The potential for role conflict for COs serving as paraprofessionals in mental health programs still exists, but can be minimized. Where such use is contemplated, the following steps should be taken:

- COs to be assigned to mental health programs should be selected carefully to ensure that they have the interest and inclination to work with the mentally ill or retarded.
- They should be assigned to fixed posts to enhance their ability to become familiar with the patients and their routines.
- Additional training should be provided for these COs by the mental health staff.
- They should be supervised by clinical staff and not by custody staff, since they are part of the mental health team.

F. Conclusions

This chapter addressed the basic components of an adequate health care delivery system. Elements of the medical, mental health and dental programs were reviewed and some of the ancillary services that support the health programs were mentioned briefly. The decision as to which health services will be provided on-site and which will be obtained in the community is a complicated one that requires balancing a number of factors including utilization data, location of community resources and cost among others.[53] Regardless of where services are offered, there are two basic precepts that must be followed: First, arrangements must be made in advance of need and second, inhouse services must follow the laws, standards and regulations that govern these professions in the community.

ENDNOTES

1. ACA (1990).
2. Dubler (1986).
3. JCAHO (1990) .
4. NCCHC (1987).
5. ANA (1985).
6. APA (1989).
7. In January 1989, the ACA did publish Certification Standards for Health Care Programs as a separate manual. These standards were designed for facilities that wanted their health services certified by the ACA rather than their entire facilities accredited. The certification standards are

not discussed separately though, since they are duplicative of standards contained in the ACA's manual for adult institutions and since they are used by only a handful of correctional facilities.

8. During the 1970s, the ACA's health care standards were more consonant with those of the health professions. At one point, in fact, they were the same, since the ACA adopted the health care standards developed by the American Medical Association for use in its prison and jail standards editions. Since that time, though, the ACA has revised its various sets of standards on its own.

9. Obviously, if the DOC operates a hospital or a free-standing mental health facility, one of the other sets should be used.

10. Dubler (1986: 7).

11. Dubler (1986: 11).

12. Intake procedures for mental health and dental care are discussed in more detail in the respective sections for these two services.

13. For more specific information on the areas to be included in the physical exam, see Dubler (1986: 1-7) and NCCHC (1987: 22-24).

14. See also Dubler (1986: 14).

15. A twenty-one year old man, sentenced to serve fifteen days in jail, died six days after admission. According to the newspaper account, both his requests for medical attention and those of other inmates on his behalf were ignored. He was told repeatedly by the officers to "fill out a kite" (a written request slip). At least two nurses making medication rounds spoke briefly to the individual and told him the same thing. By the time anyone took this young man's complaints seriously, he was in acute distress. His appendix had ruptured. He died a few hours after finally being transported to a hospital. For more information on this occurence, see the Seattle Times, 6/7/90, page 1.

16. See NCCHC (1987:20).

17. Quality assurance studies can be conducted periodically to check on "no shows" by randomly selected general population inmates. This will help to ensure that patients who need care are not "falling through the cracks."

18. See e.g., Sheps *et al.* (1987); and Twaddle (1976).

19. See e.g, Chapter I, section A; Chapter VIII; and Chapter IX, section C.

20. Nathan (1985).

21. See also the editorial by Cohen and Wishart (1983) on social medicine.

22. Paris (1989) followed 16 such confined abusers in a Florida prison for three months to track their utilization rates. He concluded that there was no ultimate solution to decrease the utilization of this group.

23. In 1990, Ronald M. Shansky, MD, and his staff at the Illinois DOC conducted a survey of the 50 state prison systems to determine the number of inmates with special needs. Staff at only about 30 of the DOCs responded and many were able to provide estimates only rather than actual data.

24. See Dubler (1986: 13) and NCCHC (1987: 37-38).

25. For more specific direction and explanation of the components of infirmary care, see NCCHC (1987: 36).

26. Providing custody staff round-the-clock to guard inpatients in a community hospital involves an added expense and a higher security risk. Some DOCs have had good success in working with local hospitals to designate a secure ward for their inmate/patients. This helps to reduce both the security risk and the cost, since inmate/patients are in a single area and one officer can guard more than one patient at a time.

27. See Brecher and Della Penna (1975: 29-32) for a more detailed discussion of the factors to be weighed in utilizing DOC facilities versus community hospitals.

28. For more information on disaster planning, see chapter IX, section B.13.

29. Additional suggestions for equipping an emergency room are listed in Appendix J.

30. See Swetz *et al.* (1989) and the references cited therein.

31. See e.g., McCarthy (1985); Swetz *et al.* (1989); Jemelka *et al.* (1989) and the references cited therein; and Weinstein (1989).

32. See Chapter VIII, section C.5. on the mentally retarded offender and the references cited therein.

33. See e.g., Teplin (1983); and several of the articles contained in volume 5, issue 1 of the *Journal of Prison and Jail Health* (1985).

34. This recommendation is consistent with that of the American Psychiatric Association. See APA (1989: 28).

35. I am indebted to Walter Y. Quijano, PhD for the many discussions we have had on this topic.

36. Again, Dr. Quijano was extremely helpful in clarifying the issues for this discussion.

37. Jemelka *et al.* (1989) argue for the case management approach in dealing with the mentally disordered offender, although they point out that in prisons, case management is less a matter of coordinating the patient's survival and more one of coordinating treatment services.

38. The utilization of psychiatric observation beds and the provision of sheltered housing for the retarded are discussed in Chapter VIII.
39. See e.g., APA (1985) and APA (1989).
40. See e.g., Conte (1973); Office of Health and Medical Affairs (1975); and Anno (1977) and (1978).
41. While the appendices are somewhat dated, the manual prepared by Easley and Lichtenstein (1979) under a grant received by the Michigan DOC still contains much useful information on establishing a correctional dental program.
42. See e.g., Rold (1988).
43. See e.g., Mehlisch (1986-87a).
44. See e.g., Block (1983), and Mehlisch (1986-87b).
45. See e.g., Barnes *et al.* (1988).
46. For a copy of the current ADA catalog, contact:
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
312/440-2500
47. See ADA (1981).
48. NCCHC (1987:29-30).
49. Dubler (1986:49).
50. Classification systems for prioritizing care based on need are available (see e.g., Barnes *et al.*, 1988). In addition, dental directors in several DOCs (e.g., Illinois, Michigan and Texas) have developed sample protocols that may be of interest.
51. See Appendix J for a sample dental equipment list.
52. R. Patrick Murphy, DDS of the Texas Department of Criminal Justice presented a paper at NCCHC's 13th National Conference on Correctional Health Care that can assist medical personnel who provide after hours coverage to determine what constitutes a dental emergency. See Murphy (1989).
53. See Chapter X for a detailed discussion of the decision-making process regarding on-site versus off-site services.

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CHAPTER VIII

PROGRAMMING FOR SPECIAL HEALTH NEEDS

A. The Scope of The Problem

The previous chapter outlined the primary components of a model health care delivery system and discussed the basic levels of care and services that should be available to all inmates. Additionally, each DOC must make arrangements to address the health needs of special populations, which is the focus of this chapter. In the medical program, patients with special health needs include women with obstetrical and gynecological problems, the terminally ill, geriatric offenders and the physically handicapped as well as patients with chronic illnesses and communicable diseases. The mental health program must address the needs of suicidal inmates, self-mutilators, substance abusers and sex offenders in addition to inmates who are mentally ill and violent, and those who may be retarded. Health programming for each type of special offender can have significant implications for staffing, housing, space and equipment -- all of which impact on cost.

Meeting the needs of these special populations may well represent the coming crisis for correctional health care in the 1990s for two reasons: first, the number of inmates with special needs is escalating rapidly and second, most DOCs are not doing a good job of identifying and serving their existing special populations.

On the first point, it is clear that today's inmates are older, sicker and staying longer than their counterparts of a decade ago. Further, there are many more inmates with which to contend. The "law and order" stance of many politicians during the 1980s resulted in mandatory sentencing and reduced utilization of alternatives to incarceration (both of which meant that more inmates went to prison) as well as fixed sentences (which meant that many inmates were staying longer). The launching of the "war on drugs" during this same period also contributed to the burgeoning prison population. The Federal Bureau of Prisons and the Florida Department of Corrections among others attribute much of their growth during the 1980s to the war on drugs.[1] Further, the prison population is aging -- owing not only to mandatory and fixed sentencing practices, but also to the fact that more older people are committing crimes.[2]

The National Council on Crime and Delinquency (NCCD) published a report in December of 1989 that was startling.[3] It showed that the United States' prison incarceration rate almost doubled in the ten-year period of 1980-1989, reaching an unprecedented rate of 250 prisoners per 100,000 population. Even more startling was NCCD's prediction that:

> *Under existing policies, the states will increase their prison populations by over 68 percent by 1994, an annual average growth rate of about 13 percent per year. This rate of growth is twice that projected by NCCD in its 1988 forecast* (Austin and McVey, 1989:1).

Austin and McVey (1989:2) went on to state that "it appears that the phenomenal growth of prison populations during the 1980s will be followed by even greater increases over the next five years, which will threaten to completely overwhelm the nation's prison systems."

What makes these predictions so sobering is the fact that most DOCs are already overcrowded and ill-prepared to deal with increasing numbers of offenders. The potential crisis for correctional health care is even more dramatic. Not only must basic health services be increased to meet the needs of a growing population, but expensive specialty services must be increased to serve those with serious health needs. Unfortunately, in many DOCs, the health services personnel not only have failed to plan for the influx of future offenders with special needs, they are unable to identify those in their current population in any systematic way.[4]

It is always possible, of course, that the dire predictions made by NCCD will not come to pass. Some states once again are exploring the possibility of alternatives to incarceration to help stem the tide of prison admissions and several states are expanding their use of good-time to shorten prison stays. While these measures may help, their implementation depends on decisions made by individuals external to correctional health care (e.g., legislators, correctional administrators). Statewide health services directors would do well to ensure that there is a system in place to identify accurately

patients with special health needs. That way, regardless of whether population predictions hold true, there will be good data upon which to plan for meeting the needs of future offenders.

The first step in identifying offenders with special health needs is simply to list the categories for which information will be sought. For example, under the medical program, the list might include individuals with chronic diseases, communicable diseases, physical handicaps and terminal illnesses as well as older offenders and females. Category headings should be established for the mental health program as well. Under each of these major headings, the specific illnesses or conditions should be listed that have implications for special health services.

It is important to be as specific as possible in defining the conditions listed under each category to avoid over-counting. For example, the *AIDS patients* category might be broken down into those who are HIV positive but asymptomatic, those who are being followed in chronic disease clinics and those who are terminally ill, since implications for the special needs of each subset differ dramatically. Similarly, under the *physical handicap* heading, breakdowns might include the blind, the deaf and the mobility impaired. The latter category might be broken down further into those who are confined to a wheelchair and those who can ambulate with the assistance of some other device (e.g., prostheses, walker).

Operational definitions should be provided for the sub-sets within each category. To the extent possible, the categories should be mutually exclusive. Offenders with more than one special need generally should be counted only in the category of their primary problem.

Once the basic categories and their subsets have been listed and defined, it is helpful to review them in terms of their implications for specialized care. Ronald M. Shansky, MD, medical director of the Illinois Department of Corrections, has developed a matrix that can assist in this task (see Appendix G). The column headings reflect the special needs categories and subsets while the row headings list implications for housing, programming (e.g., work, school), staffing (medical and other), specialty services, special space and equipment needs, and fiscal impact.

After completing this exercise, if there are any categories listed that have no implications for special services, they should be deleted from the list of special health needs. For example, amputees who ambulate well with a prosthetic device and no longer need physical therapy or the services of a physiatrist should not be counted as special needs offenders. Similarly, inmates who are HIV positive but asymptomatic generally do not require anything beyond basic health care. While it may be important for statistical or epidemiological purposes to know how many offenders there are with these conditions in the DOC, including them in the special health needs count serves only to inflate it. Since the fiscal impact of special services can be extensive, it is important to be as accurate as possible in identifying this group.

Once the special needs categories have been defined and refined, a data collection instrument can be developed to count the number of individuals in each category at a specific point in time. The data must be collected simultaneously in all institutions to avoid duplicate counting as much as possible. It is useful to conduct a training session for those individuals who will be collecting data to ensure that they understand their task. At a minimum, written instructions with clear definitions of terms should accompany the survey instrument.

Data from the survey and the matrix review will assist health planners in determining whether it is more cost-effective to centralize or regionalize each specialty service and whether they should be provided in-house or purchased in the community. After the survey has been completed, a tracking system should be established for special needs offenders currently in the system. In addition, each intake unit should have a mechanism in place to identify the special health needs of new admissions.

If correctional health administrators are to weather the coming crisis, it is imperative that data be collected systematically on the incidence and prevalence of specific diseases and conditions related to serious health needs. There is a paucity of such information in the literature. AIDS is the only disease of prisoners that is reported nationally on an annual basis.[5] Occasionally, a study is published that presents data on a specific disease or condition in a particular jail or prison system at a given point in time, but few correctional systems are routinely collecting morbidity and mortality data. Even where such data are collected, correctional health staff often are not publishing their results (although staff at the Maryland DOC are a notable exception of late).

In terms of understanding the health problems of the population it deals with, correctional medicine is significantly behind other health care fields. Undoubtedly, it will take a national organization to

serve as the impetus for creating a national repository of correctional health data and much work will have to be done to standardize the definition of terms and the data collection methodology and reporting systems. That is in the future, though. In the interim, each DOC should establish its own data collection system for use in its own planning.

The sections below address some of the more prevalent health needs of offenders that require special planning. Implications for housing,[6] special programs, staffing, specialty care, and space and equipment are reviewed.[7]

B. Special Medical Needs

1. Chronic and Communicable Diseases/ Conditions

While the terms *chronic disease* and *communicable disease* are not interchangeable, there are certain conditions such as AIDS and tuberculosis that may be classified properly as both. Only a few of these diseases are discussed in this section, either because of their prevalence, their seriousness or both. For disease entities not presented, general guidelines on managing chronic illnesses may be found in Chapter VII, section B.1.c., and on communicable diseases in Chapter IX, section C.

a. Cardiovascular Conditions

Heart disease and stroke are among the top five causes of death in the United States. While mortality data for the nation's prison systems are not available, it is likely that these two conditions represent a substantial portion of the deaths in prison attributable to natural causes.[8] Prisoners tend to exhibit a number of the factors that place them at risk for these conditions including a high percentage who smoke, have poor dietary habits and suffer from a lack of exercise. In addition, significant numbers of inmates are hypertensive.[9]

The management of hypertension in prisons is not difficult and does not usually imply the need for any special housing, programs, equipment or staff. Most of these patients can be managed adequately through regular chronic clinics where their medication can be checked, their blood pressure can be monitored and they can be counseled regarding exercise, weight control and avoiding smoking and high sodium foods. Failure to provide regular follow-up for hypertensives, though, can have serious consequences. Hypertension is known as "the silent killer" and can lead to heart attacks, strokes and kidney failure.

In their acute stages, cardiovascular conditions often involve lengthy hospital stays and the services of expensive consultants such as cardiologists or neurologists. For people with chronic conditions, a number of special services are required. Depending upon the seriousness of their conditions, some of these patients may need to be assigned to an extended care facility and others will require protective housing or special consideration in their bunk or tier assignments. Work assignments, if any, are likely to involve restrictions.[10]

Cardiovascular patients should be placed in facilities where there is immediate access to appropriately equipped and staffed emergency services and the availability of 24-hour per day nursing care. They should be seen periodically in specialty clinics by the appropriate specialist (e.g., cardiologist, physiatrist) and monitored regularly by the unit physician. Some of these patients also will require additional special services such as physical therapy, speech therapy and other rehabilitative measures.

b. End Stage Renal Disease

There are a variety of reasons why patients require dialysis. End stage renal disease may result from hypertension, IV drug abuse and AIDS among other conditions, but one of the most common causes is complications from diabetes. Diabetes is a chronic condition that can have serious consequences if not managed properly. It can cause blindness, heart attacks and strokes in addition to renal disease and can precipitate medical emergencies such as hypoglycemia (insulin shock) or ketoacidosis (diabetic coma). For these reasons, patients whose diabetes is not well controlled should be assigned to units where there is immediate access to appropriately equipped and staffed emergency services and where 24-hour per day nursing care is available.

Type II diabetes mellitus (the most common form) is found in about ten percent of the adult population in the United States.[11] While good data are not available, the prevalence of diabetes among prisoners must be assumed to be at least that much. For most of these patients, no special health programming is required beyond regular monitoring at chronic clinics.[12] They can be housed in general population and do not require any dedicated space or special equipment (besides a glucometer)

for their care. For patients with end stage renal disease, though, it is an altogether different story.

Regardless of what condition precipitated the need for dialysis, patients with end stage renal disease require extensive services. Estimates of the cost of dialyzing a single patient three times a week in a community facility range from $40,000 to $60,000 annually. Additionally, the DOC needs a dedicated vehicle to transport the patients and security staff to escort them on what is often an all day process. In most DOCs, if there are three or more patients in the system requiring hemodialysis, it will be more cost-effective in the long run to provide this service in-house, even though the initial investment in a dialysis unit is an expensive proposition. Dedicated space, specially trained staff to operate the dialysis unit, arrangements for waste disposal, the availability of dietary counseling and the services of a consultant nephrologist are needed also.

Patients with end stage renal disease usually do not require any permanent special housing, but should be placed in a prison with an infirmary so access is assured when needed. Some creativity is required in work and program assignments for these patients, since they spend several hours a week in dialysis.

c. Respiratory Conditions

Prisoners are prone to both types of respiratory conditions, infectious (e.g., tuberculosis) and non-infectious (e.g., emphysema and asthma). Tuberculosis, a disease once thought to be well-controlled in the United States, is again on the rise.[13] This is attributable, in part, to the epidemic spread of HIV infection.[14] Researchers have demonstrated that HIV seropositive subjects with a positive PPD are much more likely to develop active tuberculosis than individuals with a positive PPD who are seronegative for HIV.[15] Since prisons contain a population that is at high risk for having contracted the HIV infection,[16] DOCs can anticipate an increase in the incidence of tuberculosis (TB). A study in the New York state prison system showed that the incidence of TB among inmates increased from 15.4 cases per 100,000 in 1976 to 105.5 per 100,000 in 1986 and that the majority of inmates in 1985 and 1986 with TB also had AIDS or were HIV positive.[17]

Since TB is an airborne disease, its transmission is accelerated in crowded conditions. It is imperative that prison health professionals take aggressive measures to prevent tuberculosis and to control its spread.[18] Patients with active TB must be isolated in a room with negative airflow and staff instructed to take respiratory precautions. Once the active stage is past, TB patients do not require any special housing and can be monitored through regular chronic clinics.

The prevalence of non-infectious respiratory conditions (e.g., chronic obstructive pulmonary disease [COPD], asthma) among prisoners is unknown. In the general community, COPD is one of the five leading causes of death. Primary risk factors associated with COPD include smoking, air pollution, allergies and family history. Its usual onset is after age 50. As the prison population ages, there is likely to be an increase in the number of patients with COPD. Additionally, experienced correctional physicians[19] believe that deaths from asthma may well be the single most preventable natural cause of death among prisoners.

Depending upon the severity of their conditions, some patients with non-infectious respiratory conditions may require protective housing or consideration for ground floor, low bunk assignments. Additionally, they should be placed in non-smoking cells or dorms. Those with more advanced conditions may require placement in an extended care facility with 24 hour per day nursing care and the availability of oxygen and a consulting pulmonologist. Wherever COPD and asthma patients are housed, there should be immediate access to properly equipped and staffed emergency services.

Patients with respiratory conditions who are able to work should not be placed in jobs where they are exposed to environmental pollutants. Those with more advanced conditions will not be able to work at all. The clinic should have respiratory therapy services available and patients should be monitored regularly regarding their pulmonary function. Special equipment including a peak flow meter, a nebulizer, portable oxygen tanks and emergency drugs should be readily available.

d. Seizure Disorders

Very little is known about the prevalence of seizure disorders among prisoners. The National Library of Medicine in its 1990 bibliography on prison health care listed only two publications on epilepsy among prisoners and one was ten years old. What little evidence is available suggests that the prevalence of epilepsy is higher among prisoners than in the general population.[20] King and

Whitman (1981:18) hypothesize that this is the case because "...poor people have higher prevalence rates of epilepsy, and...they are also the great majority of prisoners." The causes of seizure disorders include head trauma, drug and alcohol withdrawal, and pre-natal and perinatal morbidity -- all of which occur more frequently among the poor.

The most expensive aspect of caring for patients with seizure disorders is often in the diagnostic phase, which requires a comprehensive history, a thorough physical examination, and special services such as an electroencephalogram (EEG), a computerized tomographic (CT) scan and a neurological work-up.[21] Once the diagnosis is made, most seizure disorder patients can be controlled adequately on medication and monitored in chronic clinics with periodic consultation by a neurologist as needed.[22] Owing to the possibility of status epilepticus, seizure disorder patients should be placed in prisons that have immediate access to properly equipped and staffed emergency services. Most prisons housing inmates with seizure disorders will find it is more cost-effective to have an EEG machine in-house.

Virtually all seizure disorder patients can be placed in general population, but should be housed on the ground floor and in a low bunk. At least one study suggests that seizure disorder patients not be housed in a single cell.[23] Given their potential for seizures, work limitations for these patients often are required. A number could benefit from vocational education programs designed with their disability in mind (e.g., computer operators). Owing to the stigma associated with epilepsy and the mistaken notions regarding appropriate first aid, an aggressive health education program for both inmates and staff can be important to the care of patients with seizure disorders.[24] Additionally, a number of these patients may require supportive counseling to help them adjust to the social problems that often accompany this condition.

e. AIDS

In contrast to the diseases/conditions discussed above, a great deal has been written about AIDS among prisoners. The National Library of Medicine's 1990 bibliography on prison health care lists 229 references on HIV and AIDS published between 1986 and 1990. The annual incidence of AIDS in prisons is substantially higher than in the population at large, owing primarily to an over-representation of individuals with histories of high risk behaviors, especially intravenous drug use.[25]

The cost of caring for AIDS patients is substantial.[26] They require expensive medications, the care of AIDS specialists, and are likely to be in and out of hospitals and infirmaries. In their terminal stage, many AIDS patients need continual care in a hospice or nursing home environment. Prisons providing care for several inmates with AIDS should have a respiratory therapist in-house and appropriately ventilated space to offer aerosolized pentamidine treatments. HIV positive inmates also can benefit from the prophylactic application of pentamidine.

Except when clinically indicated, AIDS patients do not need to be housed separately from the general population. In its 1990 policy statement, the National Commission on Correctional Health Care stated:

> *The Commission does not advocate segregated housing for HIV positive inmates who have no symptoms of the disease. Since the AIDS virus is not airborne and is not spread by casual contact, HIV positive inmates can be maintained in the general population in whatever housing is appropriate for their age, custody class, etc. However, AIDS patients may require medical isolation for their well-being as determined by the treating physician.*[27]

Extensive counseling services are required for inmates prior to being tested for the HIV virus, after learning that they are HIV positive, and at all stages during the progression of their disease. Work and program restrictions are not required for asymptomatic HIV positive inmates. That status alone should not prevent them from holding jobs (including kitchen assignments), going to school or participating in regular prison activities (e.g., recreation, religious services, library). For AIDS patients, work and program limitations should be determined by the treating clinician.

2. **Special Needs Of Women**

In any DOC, women usually represent four to seven percent of its total population. Adult female offenders are subject to the same types of chronic and communicable diseases and other physical and mental impairments as their male counterparts, although sometimes at different rates.[28] Their

unique health needs are associated with the female reproductive system. Thus, they require the same types of basic and specialty health care as males, but also need access to obstetrical and gynecological services.

Any institution housing women must provide for their special health needs. In addition to the basic and specialty services offered to males, the following should be available for females:

- The intake history should include questions regarding the patient's menstrual cycle, pregnancies and gynecological problems.

- The intake examination should include a pelvic exam, a breast exam, a Pap smear, and depending on the patient's age, a baseline mammogram.

- Laboratory tests to detect sexually transmitted diseases (STDs) including gonorrhea, syphilis and chlamydia should be provided for all females, especially since many are asymptomatic for STDs. Additionally, where medically appropriate, females should receive a pregnancy test on admission to the DOC.

- The frequency of repeating certain tests, exams and procedures (e.g., Pap smears, mammograms) should be based on guidelines established by professional groups such as the American Cancer Society and the American College of Obstetricians and Gynecologists, and should take into account age and risk factors of the female prison population.

- Women should have ready access to personal sanitary supplies including tampons.[29]

- All females should be provided with health education information on breast self-examination, contraception and pregnancy.

- Consistent with state and federal laws and regulations, pregnant offenders should retain the right to choose abortion or continuation of pregnancy. Pregnancy counseling and abortion services must be available.[30]

- Pregnant inmates must have access to regular pre-natal care, and receive dietary supplements (e.g., milk, extra food, pre-natal vitamins) as prescribed by their physician.

There is another issue concerning women that should be mentioned briefly. APHA's standards[31] state that contraceptives should be continued for women who request it. This makes perfect sense for those who are incarcerated for short periods of time, but not for the majority of state prisoners serving sentences of several months or years. Occasionally, there is a patient who has birth control pills prescribed as treatment for menstrual irregularities and this should be continued at the discretion of the prison physician. Additionally, women who are on birth control pills when they are admitted to the DOC should be allowed to complete their current cycle. Otherwise, it is expensive, impractical and unnecessary to continue women on birth control pills or other contraceptive devices throughout their incarceration.

Some may argue that in the absence of contraceptives, female offenders are at risk for pregnancy, STDs or AIDS. They are, but the possibility of becoming pregnant or contracting STDs or AIDS while incarcerated in a women's prison is remote. Male staff members who engage in sexual activities with female offenders are subject to immediate dismissal and sometimes, criminal prosecution. Further, evidence of female to female transmission of AIDS and STDs is rare. A more practical policy for DOCs is to provide contraceptive devices for women based on medical need or potential risk (e.g., females residing in co-ed institutions, prior to being placed on furlough or in a work release program).

Except as indicated by their specific health conditions, women do not require special medical housing based on gender alone. Most of their unique health needs can be managed adequately in ambulatory settings with follow-up in OB/GYN specialty clinics as required. One potential exception is pregnant inmates. Owing to the large percentage of high risk pregnancies among prisoners, some DOCs house all pregnant inmates in the same area. This facilitates the medical monitoring of their pregnancies, makes it easier to determine who is complying with their pre-natal regimens, and

provides a built-in peer support group. Any prison housing pregnant inmates must have immediate access to appropriately equipped and staffed emergency services.

Work and program limitations based on gender alone apply primarily to pregnant inmates. Restrictions for other women are dependent on age and disease/condition factors.

Special staffing includes those already mentioned (e.g., health educators, pregnancy counselors, OB/GYN specialists) as well as an increased number of social workers and mental health counselors. Female offenders tend to require more social planning services and more supportive therapy than males, often revolving around issues of pregnancy and children. One study reported that "...between 50 percent and 70 percent of incarcerated women have one or more dependent children who were living with them prior to their imprisonment."[32] Separating mothers and children has profound emotional effects for both groups. The issues of whether babies should be kept in prison with their mothers or what should be done to foster mother/child relationships for incarcerated women are too complex to resolve here.[33] Nonetheless, prisons holding females should be prepared to deal with the emotional crises that such separation brings.

Equipment requirements for treating females' unique ambulatory health needs are minimal (e.g., exam table with stirrups, goose neck lamp, instruments and supplies to conduct pelvic exams and Pap smears). Few DOCs have a sufficient number of older women (i.e., 35 and above) to justify a mammography machine in-house, and delivery of all babies always should be accomplished in a licensed hospital with delivery facilities for high-risk pregnancies.

Before leaving this section, one final point should be made. The literature on female offenders is replete with examples of inequality in their housing arrangements, the availability of programs and their access to services when compared with their male counterparts.[34] Both APHA's and NCCHC's standards are predicated on the assumption that females have access to the same basic and specialty care as males in addition to services designed to meet their unique health needs. Two recent articles discuss the legal implications of failing to provide parity in services and programs for female offenders.[35] Both conclude that DOCs can anticipate increased litigation around these issues, especially since the female population is growing both in absolute numbers and in percent of those incarcerated.

3. Physically Handicapped

The physically handicapped include the mobility impaired (e.g., amputees, the wheelchair bound, those who ambulate with assistive devices such as canes, crutches, walkers) and individuals who are visually impaired, hearing impaired and/or speech impaired. The number of people in prison with these disabilities is not known. Veneziano *et al.* (1987) conducted a survey of state and federal correctional systems to identify the number of handicapped in each. They concluded:

> *In summary, it appears that there are inmates in our prison systems with special handicaps and thus with special security and treatment needs. Exact numbers are not known; the reliability of the available data is in question due to: (1) differences in definitions of handicaps, and (2) differences in and/or lack of screening and evaluation of handicaps. The present research suggests that handicapped inmates are not singled out for differential treatment, and that little is known about the scope of their difficulties during or after the time they spend in prison....There appears to be a need to systemize evaluation and treatment of inmates with specific handicaps, given the difficulties they are likely to encounter in prison and afterwards* (p. 71).

Three years later, the results of the national special needs survey conducted under the auspices of the Illinois Department of Corrections showed that not much had changed.[36] Few states were systematically identifying, evaluating and tracking patients with special needs. The data on mobility impaired inmates was somewhat better, since these individuals are highly visible. The 28 correctional systems responding on this item reported a range of 0.04 to 1.2 percent of their total populations had problems ambulating.[37] The percent of inmates with other physical disabilities was not reported.

Programming for the physically handicapped in prisons represents a major challenge. The special needs of this group of offenders cut across all aspects of prison life. The responsibility for programming for this population often rests with the health services division of the DOC, although this is neither a necessary nor even a logical placement. The health

needs of the physically handicapped are usually the easiest to address. Regardless of which department of the DOC is assigned the primary responsibility for programming for the physically disabled, it is imperative that a cross-disciplinary planning group be established. This group should include representatives from the following areas: custody, classification, construction, medical, dental, mental health, vocational services, educational services, religious services, social services and recreation.

Additionally, once the planning is completed and a program for the physically disabled is operational, it is suggested that a case management approach be adopted for their continuing care. Each physically disabled offender should be assigned to a specific case manager who coordinates all services and follows the patient throughout his/her incarceration. Case management is the best approach to ensure that services are neither fragmented nor duplicated.[38]

The special needs of specific types of physically disabled offenders are discussed below. In addition, it is suggested that DOCs ask their legal counsel to review the provisions of the "Americans with Disabilities Act of 1990," to see what impact this federal legislation may have on programming for the disabled.[39]

a. The Mobility Impaired

Individuals who have difficulty ambulating should be placed in a barrier-free facility, which is easier said than done. Except for perhaps the newest prisons, few existing institutions are truly "barrier-free." Even in prisons where physical alterations have been made, there tend to be areas such as disciplinary housing that are overlooked. The cost of converting existing prisons to barrier-free facilities can be extensive, especially since many older institutions do not lend themselves readily to the necessary architectural modifications. To illustrate, a partial list of barriers might include:

- narrow doorways that do not permit wheelchair access;
- the presence of stairs that may prohibit access to institutional programs;
- insufficient cell space to accommodate wheelchairs, walkers etc.;
- lips on doorways that prevent access;
- toilets in housing and program areas with high seats and without handrails;
- showers not equipped for use by the mobility impaired;
- drinking fountains out-of-reach for the wheelchair bound; and
- food lines and dining tables inaccessible to the mobility impaired.

While some states (e.g., Illinois) are attempting to remove barriers in several institutions to allow more flexibility in housing the mobility impaired of different custody classes, other DOCs (e.g., Texas) have opted to house all of their male mobility impaired with special needs in a single barrier-free institution.

Within a barrier-free facility, there are a certain number of the mobility impaired who also require special housing. Some need a protective environment owing to the possibility of victimization. The wheelchair bound require larger cells or dormitory space to accommodate their equipment. A few of the mobility impaired need constant care in an infirmary or nursing home environment. Patients with certain spinal cord injuries must be housed in air conditioned areas.

Work restrictions are likely for this group of offenders owing to their physical disabilities, but a number of amputees and wheelchair users are work-capable. They should have access to jobs where their disabilities are not a handicap. Others can benefit from vocational training or academic programs. Recreational opportunities should be available as well.

The special medical needs of the mobility impaired often include regular monitoring by a physiatrist and the availability of physical therapy and other rehabilitation services. If the latter are provided in-house, dedicated space and special equipment are required. Each DOC should have at least one van that is specially equipped to transport inmates with mobility impairments. Increased mental health services are needed as well to help such patients adjust to the limitations and social stigma associated with their disabilities.

b. Other Disabilities

Some inmates may be visually impaired, hearing impaired or speech impaired and thus, require

special services. Most of them can be housed in regular population assignments, but those with severe disabilities (e.g., blind, deaf, mute) may need protective housing owing to the possibility of victimization. By themselves, these conditions do not require any special medical housing.

Work restrictions are necessary for inmates with severe visual, hearing or speech impairments, but most are capable of working in some capacity. Many can benefit from special educational and vocational programs designed to accommodate their particular disabilities.

This group of offenders has few special medical needs created by their conditions. The services of specialists (e.g., ophthalmologists, audiologists, otolaryngologists) are important in initial diagnosis and for those who can benefit from continued monitoring and intervention. Inmates with permanent disabilities, though, require more in the way of social services and supportive counseling than they do medical care for these conditions. Individuals who are blind, deaf or severely speech-impaired may suffer from depression and have difficulty coping with the limitations and social ostracism that accompany their disabilities.

Some inmates with speech and hearing difficulties can benefit from speech therapy. Others require the services of an interpreter in order to participate in any part of regular prison life. Health professionals should be aware of the special problems created in accurate diagnosis and treatment of patients when an interpreter must be relied upon to provide complaints and symptoms of illness.[40]

Each of the specialties (e.g., ophthalmology, otolaryngology) and ancillary services (e.g., audiometry, speech therapy) necessary to test, diagnose and treat patients with visual, hearing and speech impairments has its own equipment needs. Cost benefit analyses should be conducted to determine whether it is better to provide these services in-house or purchase them in the community.

4. Geriatric Offenders

According to the U.S. Bureau of the Census, the elderly are the fastest growing segment of the population in the United States. Advances in medical science have contributed to more people living longer. This fact -- coupled with mandatory sentences, longer prison terms, and more restrictive release policies -- has meant an increase in the number of elderly incarcerated. The NCCD's study states that "...increasing numbers of offenders above the age of 40 are being sentenced to prison. This age group, while still a minority of all prison admissions, is the fastest growing group of inmates in many states."[41]

It is difficult to obtain exact data on the number of elderly in prison, largely because definitions of *elderly* differ dramatically from jurisdiction to jurisdiction and across disciplines. Criminologists may define anyone over 30 as "old"[42] while gerontologists are more likely to use age 65 or over as their benchmark. The Federal Bureau of Prisons and some states use age 45 to define older offenders whereas other states use age 55 or 60.[43] A number of researchers on elderly offenders have settled on "age 55 or older" as their operational definition of elderly[44] and one even states that:

> *It is somewhat ridiculous...to talk of 50 as an entrance to old age. Available research shows that age 55 is the starting point of physical and mental deterioration; that most chronic illnesses begin at this age, and that many of the aged's social needs become accentuated at this age.*[45]

On the other hand, some experienced correctional health practitioners argue for a lower age definition of elderly among the incarcerated. They note that inmates' biological ages frequently are considerably higher than their chronological ages owing to substance abuse, smoking, poor nutrition and a lack of prior care among other factors.[46] The survey conducted by the Illinois DOC used *50 and older* as its definition of elderly. Of the eighteen states responding to this item, the percentage of their populations who were age 50 and older ranged from 1.4 to 7.7 percent.[47] On a national basis, the number of offenders age 55 and older in state and federal correctional institutions in 1988 was more than three percent of the total population (18,800 out of 597,000), which represented a 50 percent increase in the number of older offenders in just four years.[48]

Regardless of how *elderly* is defined, it is clear that older offenders have increased health care needs. For one thing, they are more likely to suffer from chronic illnesses than younger inmates. One study of 41 men aged 50 to 80 who were housed in a Michigan prison found that 83 percent had at least one chronic health problem and almost half had three or more chronic health problems.[49] For another, there are a host of bodily changes that

accompany the normal aging process that can lead to health problems including vision and hearing loss, tremors, sleep disturbances, gastrointestinal disorders, incontinence and mental confusion.[50]

While many older inmates do not require special housing, those who are disabled or infirm should be placed in a protective environment owing to the possibility of victimization. Those with chronic illnesses are likely to have increased utilization of infirmary and hospital services, and a certain number may need extended nursing care and assistance with daily living skills. Work and program restrictions are inevitable for this group of offenders, but few DOCs have developed alternative programs for the elderly. One state that has (Michigan) reports good success with its age-segregated program on all measures of improved inmate welfare except utilization of health services.[51] Another state (North Carolina) has a special program at the McCain Prison Hospital to provide care and support for elderly inmates in a nursing home environment, and the Maryland DOC has an elderly offenders project designed to coordinate placements and services for this population. Age-segregated programs are still the exception, though.

Prisons housing elderly offenders should have immediate access to properly equipped and staffed emergency services, and the availability of round-the-clock nursing care. The increased need for health services among the elderly means a concomittant increase in regular health staff and the availability of specialists to address their chronic and age-related illnesses and conditions.

If current trends continue, the increased costs of housing and caring for elderly offenders will represent a substantial portion of most DOCs' budgets. Sol Chaneles, a criminologist, predicts that "[i]n 20 years, most prisons are going to be geriatric prisons. By the year 2000, prisons will be renamed 'Centers for the Treatment of Old Folks.'"[52] An alternative to this dire prediction (in addition to changes in sentencing guidelines) is to initiate early release programs for the elderly. One promising effort in this direction is the POPS (Project of Older Prisoners) program operated by the Tulane University Law School in Louisiana.[53]

5. The Terminally Ill

A number of the conditions and illnesses discussed above are progressive and eventually lead to a terminal stage, which can be defined as a life expectancy of one year or less. It is very difficult to obtain accurate statistics on the number of terminally ill in prisons, since by definition, this is a fluid category. Not only does the usual methodological problem exist -- i.e., new inmates enter and others leave this category (through death or release from prison) at any time during a given year -- but also the category is not mutually exclusive. Inmates who are terminally ill are likely to be counted in the category of their primary illness (e.g., AIDS, cancer, COPD, ESRD) as well. Definitional problems exist also. The Illinois survey found that 0.5 percent of inmates in the DOCs reporting were terminally ill, but the author of the report noted that this figure was suspect since some states included individuals who were only HIV positive or who had debilitating but not necessarily terminal conditions (e.g., quadriplegics).[54]

Regardless of the exact number, every DOC must provide for the needs of terminal patients. These individuals have more frequent utilization of infirmary and hospital services, and as they progressively weaken, often require 24 hour per day nursing care. For many who are in the terminal phase of their illnesses, little medical intervention can be provided.[55] The primary health goal is to keep them comfortable and pain-free, and to help them adjust to the concept of death. Supportive counseling from the clergy, mental health professionals or those specially trained to deal with the problems of death and dying (e.g., thanatologists) is essential. Terminally ill patients often experience anger, anxiety and depression, and there is an increased risk of suicide.[56]

Dying with dignity is difficult under any circumstances, but it is particularly hard to achieve in prisons where individuals may be both physically and emotionally isolated from family and friends. There are two approaches that hold promise in meeting the needs of terminally ill prisoners: one is to develop special programs in-house and the other is to increase the utilization of compassionate release. Both options should be pursued. In regard to the former, the Connecticut DOC has established a program for the terminally ill at its Somers unit. These patients are housed in a separate section of the infirmary. A thanatologist works with the terminally ill and their families. Supportive counseling, group discussions, special activities, and assistance in planning for death (e.g., writing wills) are offered.[57] The Orient Correctional Facility in Ohio also has a special program for terminally ill patients that is based on a hospice philosophy.[58]

Compassionate release programs are another approach that can be used with terminally ill patients. In its 1988 survey, the Texas Department of Criminal Justice (TDCJ) noted that 15 of the 40 responding state DOCs had provisions for transferring terminally ill prisoners to non-correctional care settings.[59] The Illinois DOC's 1990 survey reported that 21[60] of the 30 responding state DOCs had compassionate release programs.[61] Unfortunately, neither survey reported the frequency with which compassionate release was used. A report of the Correctional Association of New York (1990) suggests that the availability of early release mechanisms does not mean that this option is used routinely. Of the five states with the largest number of HIV-infected inmates,[62] only New Jersey and Texas reported that their governors had granted executive clemency to any prisoners with AIDS.[63]

Given the extent of crowding in our nation's prisons and the unlikelihood of recidivism among the terminally ill, the possibility of early release for these individuals should be explored aggressively.[64] DOCs are cautioned, though, against the "dumping syndrome" that displaced so many of the nation's mentally ill when the decision was made to deinstitutionalize them. Responsible release policies mandate that provisions be made for continuing care of the terminally ill in community settings.

C. Special Mental Health Needs

1. Self-Mutilators and The Aggressive Mentally Ill

At first glance, these two categories of inmates with special mental health needs appear to be unrelated, but they share some important commonalities. To begin with, both types of offenders present extreme management problems for correctional officials. Whether inmates' aggression is turned inward or outward, such acting-out behavior is difficult to address and control in a regular prison unit. Secondly, there are times when both types of behavior are associated with underlying mental illness and times that they are not.[65] In evaluating such behavior, traditionally trained psychiatrists and psychologists may well determine that self-mutilators or aggressive mentally ill inmates do not meet the criteria for admission to an inpatient psychiatric program.

There is probably nothing more frustrating to individual wardens than to be told by a clinician that an inmate who has repeatedly slashed his throat is not mentally ill or that an inmate with a psychiatric history is not "mad" at the moment, just "bad." All too often, self-mutilating inmates and the aggressive mentally ill are shuttled back and forth between regular prison units and inpatient psychiatric facilities. Unit staff keep referring them for treatment because they do not know how to manage them, and staff at the psychiatric facility keep refusing them because they do not meet standard criteria for inpatient care. Often, the default option for such inmates is placement in restraints or administrative segregation, neither of which serves either the inmate or the institution well. These are temporary solutions at best that do nothing to address the underlying problem.

Someone must take the lead in developing programs to manage self-mutilators and the aggressive mentally ill in prison. Logically, this responsibility should rest with mental health professionals. In the previous chapter, it was argued that in prison, the threshold for mental health services should be lower than that used in the community.[66] The failure of traditional prison mental health programs to address the needs of self-mutilators and the aggressive mentally ill add strength to those arguments. Lowering the barriers to care may mean that inmates do not have to resort to extreme behaviors to gain attention.

As part of the preparation for this book, Walter Y. Quijano, PhD, a clinical psychologist, visited six DOCs during 1990 to review their mental health programs.[67] Two states had specific programs to address the management of self-mutilators and aggressive inmates. Of the South Carolina DOC's mental health program, Dr. Quijano concluded that:

> *...the traditional conflict with security is minimal because distinctions between clinical and management tasks are not exaggerated and mental health services are considered management tools for correctional failures. Security acknowledges and is grateful for the positive impact of mental health services in administrative segregation and self-mutilation.*[68]

In the New York DOC, mental health services are provided by the state mental health system but within the prison setting (except for tertiary care). Of this mental health system, Dr. Quijano stated that:

Innovative approaches such as vigorous transitional care, the mandatory presence of clinicians in administrative segregation areas, and easy access to transitional care by self-mutilating inmates have shown results in lesser inpatient care admissions and crises among self-mutilators and ad-seg inmates.[69]

Subsequent correspondence with Dr. Quijano yielded additional advice on the management of self-mutilation and explosive disorders in prisons. Because his comments can assist DOCs in establishing programs to manage these offenders, they are reproduced below in their entirety.

Special Populations: Self-mutilation and Explosive Disorders

Walter Y. Quijano, PhD
December 3, 1990

Although adequate behavioral and pharmacologic technologies exist for behavioral and psychiatric disorders, their management in the correctional setting is made more difficult by a prevailing apprehension among custody and clinical staff of being manipulated into delivering psychiatric services which, even for conventional thinking and affective disorders, sometimes are seen as pampering inmates. The suspicion of malingering and its accompanying withholding of services are particularly acute in the management of self-mutilation and explosive disorders. Yet, self-mutilators and individuals with explosive disorders, though a small number, are common in prisons and when ignored or not managed appropriately, result in deterioration of psychological well-being and in the end, usurp a disproportionate amount of resources. Thus, in the long run, the effective management of these disorders, necessarily a conjoint effort between custody and clinical staff, not only benefits inmates with these disorders but also contributes to the order of the prison and the cost-effectiveness of the psychiatric services department.

a. Self-mutilation. Self-mutilation is the deliberate infliction of injury on one's body without the expressed intent to commit suicide. It is not a monolithic phenomenon and its etiology is varied though not well understood. In general, self-mutilation in the prison may be classified primarily as one of the following: 1) a psychiatric symptom; 2) a manipulative gesture for safety reasons; 3) a manipulative gesture for convenience; 4) a self-reinforcing behavior; or 5) a behavior with no apparent motivation. Each class calls for its own management technique. The following protocols are suggestive of what can be done.

Protocol #1: Self-mutilation as a psychiatric symptom. Inmates whose self-mutilation is judged by an attending clinician to be a symptom of a major psychiatric disorder should be clinically managed (preferably in a psychiatric inpatient facility) where a thorough psychodiagnostic work-up with self-mutilation as the presenting problem can be conducted. An important component of the evaluation process is complete neurological and neuropsychological examinations. The management of self-mutilation becomes secondary to the aggressive management of the psychiatric disorder (e.g., major affective disorder, major thought disorder, anxiety disorder with panic, depersonalization disorder, and borderline personality disorder) of which self-mutilation is considered a symptom. Incidents of self-mutilation among psychiatric patients with subtle symptoms tend to increase with the difficulty of access to care. The New York and South Carolina prison systems have successfully reduced incidents of self-mutilation by reducing barriers to psychiatric services. Unit assignment at discharge from the inpatient facility should take into consideration environmental factors that may precipitate decompensation. One idea is to assign the discharges to units with a mental health staff specially trained in the management of self-mutilation in order to maximize generalization of coping skills gained in the inpatient facility.

Protocol #2: Self-mutilation as a manipulative gesture for safety reasons. Inmates who are found to self-mutilate in order to manipulate themselves out of a dangerous setting (e.g., cell, wing, prison unit

assignment) due to a perceived threat against their lives and/or limbs should be immediately provided safe housing in their current prison unit assignment. Having secured the temporary safety of the inmates, the attending clinician should promptly conduct a thorough psychodiagnostic evaluation to rule out psychiatric disorders correlated with the self-mutilation. If correlated psychiatric disorders are found, the inmates would be treated following Protocol #1 noted above. In each case, the attending clinician should promptly consult the warden who is requested to investigate the reality of the perceived threat. If the threat is verified by custody investigation and no correlated psychiatric disorders are found, the custody line of responsibility assumes the task of securing the safety of the inmate. This may involve change in housing assignment at the cell, wing, or unit level. If the threat is verified and a correlated psychiatric disorder is found, the custody line of responsibility assumes the task of securing the safety of the inmate while psychiatric treatment is simultaneously provided promptly at the current prison unit of assignment and subsequently in a psychiatric inpatient facility. Unit assignment at the time of discharge from the inpatient facility should, of course, take the threat issue into consideration.

Protocol #3: Self-mutilation as a manipulative gesture for convenience. Inmates who engage in self-mutilation in order to acquire secondary gains of convenience should be placed immediately in protective custody until such time as the attending clinician, the warden, and the offending inmates agree that the inmates can re-assume responsibility for and control over their behaviors in general and self-destructive gestures in particular. The principal technique in this type is the combination of punishments processed and administered by the custody line of responsibility and behavioral contracting involving the attending clinician acting as team leader, the warden, and the offending inmates. As part of the punishment component, there should be a systemwide uniform minimum time (e.g., two weeks) to be spent in restrictive housing which accumulates with the number of repeated self-mutilation incidents. For example, the first incident would lead to a minimum of two weeks in restrictive housing. The second incident would result in four weeks of restrictive housing, and so on. It must be remembered that the efficacy of this approach may not be felt until some accumulation of restrictive housing time is accomplished. The team must insure that minimal or no secondary gains are actually acquired. The behavioral contracting method should include assertiveness training and education on ways and means of legitimately acquiring conveniences in the prison.

Protocol #4: Self-mutilation as a self-reinforcing behavior. Inmates who engage in self-mutilation for its intrinsic positive after effects should be treated using Protocol #1 with the emphasis on long term observation and psychodiagnostics. Training in naturally self-reinforcing activities including relaxation training, rigorous exercise, biofeedback, and management of leisure activities should be conducted. Opiate receptor antagonists should be considered.

Protocol #5: Self-mutilation with no expressed motivation. Inmates who engage in self-mutilation for no apparent reason should be treated following Protocol #1 with emphasis on psychodiagnostic evaluations.

These protocols are not the final word in the management of self-mutilation and individual prison units may develop locally adapted protocols. The important consideration is that self-mutilation is addressed, not just ignored, and its complexity recognized.[70]

b. Explosive Disorders. Two classes of disorders are addressed in this section: intermittent explosive disorder as defined by the DSM-III-R and persistent intense anger. Verbal and physical assaults secondary to these disorders are characterized by impulsivity, lack of premeditation, inability of the individual to modulate his behavior, disproportionate response to the perceived provocation, and remorse after the acting out. They should be distinguished from deliberate and purposeful attacks. These disorders and their accompanying behavioral expressions

should not be automatically, simplistically, and solely considered as symptoms of anti-social personality disorder which are managed by punishment and physical restrictions alone. While housed to ensure the safety of others, behavioral, psychotherapeutic, and pharmacologic therapies (e.g., contingency management, anger management and carbamazedine) must be provided. Successful management should help integrate inmates into the general population and reserve expensive administrative housing units as the intervention of last resort. A university-based medical school sponsored study in the Texas prison system has found encouraging preliminary results in the use of attention and phenytoin in the management of impulse dyscontrol inmates.[71]

An innovative program that holds promise for the management of the aggressive mentally ill offender was undertaken by the TDCJ in June of 1990. It is an inpatient program for aggressive inmates that does not require that such inmates even be on the current psychiatric caseload. Most of the referrals are anticipated to come from administrative segregation units. The purpose of the treatment program is: "...to decrease hostile aggression while increasing the patient's ability to meet his needs using prosocial behavior. The therapeutic techniques employed [are] derived from behavior therapy and cognitive behavioral therapy."[72] Behavioral techniques used include extinction responding and the level system of earning privileges. Cognitive behavioral techniques include individual counseling, psychoeducational classes and guided group therapy. The program plan provides for outcome evaluations to be conducted.[73] It is hoped that the results of such evaluations will be shared with the correctional health community.

2. Suicidal Inmates

Suicide in confinement settings has not been studied widely. There are a few studies that have examined characteristics of suicides in specific jails and lockups[74] and two national surveys that compiled profiles of suicide victims in holding and detention centers.[75] Similar research has not been conducted on suicide among state prisoners in the United States. Only two recent publications were found that discuss suicide in state DOCs: Anno's review of suicides in the Texas prison system[76] and Salive *et al.*'s study of suicide deaths in Maryland prisons.[77] Both studies indicated that the risk of suicide was higher among prisoners than among the population at large. Other similarities of results occurred as well. In both studies:

- All victims were male.
- Their average age was 29 years.
- Whites were disproportionately at risk.[78]
- Offenders charged with crimes against the person (especially death-related offenses) were disproportionately at risk.
- No pattern was established regarding the duration of confinement at the time of suicide.[79]
- Hanging was, by far, the preferred method of suiciding.[80]

Anno also found an increased risk of suicide associated with a history of mental illness and some evidence of an increased risk associated with a history of prior suicide attempts.[81] Both findings are consistent with those reported in the general suicide literature.

While good data on the frequency of suicide in prisons are still needed,[82] suicides (and homicides) in confinement are likely to be among the most preventable deaths. Suicide prevention techniques include screening procedures, architectural considerations, monitoring/observation patterns and interaction techniques.[83]

Obtaining a history of prior suicide attempts as well as current suicidal ideation should be part of the initial mental status exam for all inmates. Equally important are crisis intervention teams[84] who are trained to assess suicide risk at any point during an inmate's incarceration. Available research suggests that among state prisoners, there is no one period of highest risk associated with duration of confinement.[85] Further, mental health staff are cautioned against the use of profiles (especially those based on demographic characteristics) to attempt to predict suicide risk.[86] Current situational stressors are likely to be more salient indicators.

If an inmate has been identified as potentially suicidal, s/he may require special housing on a

temporary basis such as placement in a psychiatric observation cell. It is imperative that such cells be constructed following recommended guidelines for suicide-proofing (e.g., no electrical outlets, no protrusions of any kind, security screening on the inside of any bars).[87] The inmate should be monitored at a frequency commensurate with his/her level of risk and referred to a mental health professional for determination of a continuing care plan.

While male inmates in maximum security institutions may have an increased risk of suicide,[88] no prison is exempt from the possibility. Every prison needs a comprehensive suicide prevention plan that addresses these elements:[89]

- identification of potential suicides;
- training of correctional and health staff to recognize potential suicides;[90]
- assessment of suicide risk by mental health professionals;
- procedures for placing the potential suicider in special housing as needed;
- monitoring procedures that designate level of staff, frequency of checks and documentation requirements;[91]
- procedures for referral for continuing care as needed;
- procedures for releasing the individual from suicide watch;[92]
- procedures for notifying appropriate correctional and health staff of the inmate's suicide status;
- intervention techniques if a suicide is in progress;
- notification of appropriate authorities in the event of a completed suicide; and
- a full medical and administrative review after any completed suicide (including a psychological autopsy)[93] to determine whether any changes are needed in the suicide plan.

In spite of everyone's best efforts, it is not possible to prevent all suicides in prison. There always will be inmates who offer no clues as to their suicidal intent. Nonetheless, implementing the procedures outlined above will reduce the opportunity for suicide and should reduce the prison's potential liability as well.[94]

3. Sex Offenders

It is difficult to say anything meaningful about the management of sex offenders in prisons and still be brief. In contrast to some of the other categories of special needs offenders discussed above, reams have been written about this group of inmates.[95] Even so, there are no absolute guidelines that have been accepted for the identification, management and treatment of sex offenders within a correctional setting.

One of the problems involved in deciding on treatment programs for sex offenders in prisons is their sheer number. One national study reported in May of 1987 that there were over 55,000 sex offenders in state prisons,[96] which at that time represented over ten percent of the prison population.[97] Some states reported that as many as a third of their prisoners were sex offenders.[98] Vaughn and Sapp (1989) suggest that whatever the reported number of sex offenders is, it is likely to be seriously understated since first, a substantial number of sex offenses go unreported altogether, and second, there is strong motivation for those charged with sex offenses to seek a plea bargain and plead guilty to a non-sexual offense. Within the prison's social hierarchy, sex offenders have the lowest status.[99] The stigma associated with sexual deviance also helps explain why "hidden" sex offenders are not likely to seek treatment voluntarily.

Another problem associated with this group of prisoners is their sentence length. Greater societal attention to the problem of sexual victimization in the community during the 1970s and '80s led to a series of changes in state sentencing guidelines for individuals convicted of sex crimes.[100] Not only are DOCs confronted with large numbers of sex offenders, but they are keeping them for relatively long periods of time. This, too, impacts on the decision as to which sex offenders to treat and for how long.

A third confounding factor in the management of sex offenders is disagreement among professionals as to whether they are "sick" or poorly socialized.[101] Determining the etiology of

deviant sexual behavior has obvious implications for its treatment and affects the decision as to whether a medical model, a psycho-social model or a behavioral model will be employed. Several of the articles contained in the NIC manual on treatment of the incarcerated male sex offender suggest that different treatment modalities need to be used for different types of sex offenders.[102]

Finally, there are those who question the efficacy of implementing sex offender treatment programs while individuals are incarcerated. Evaluations of community-based treatment programs have shown mixed results. Evidence of successful outcomes in correctional programs is even harder to come by.[103] There is little scientific information to demonstrate that existing treatment programs have a positive impact on either behavior change or recidivism.[104] Additionally, the latter is a negative outcome measure fraught with its own methodological problems, not the least of which is the necessity of successfully tracking offenders once they are released from prison.

With all of these problems, it is no wonder that "sex offender treatment systems on a statewide basis are relatively rare."[105] While virtually all states offer some treatment to some sex offenders,[106] a systematic approach to managing the needs of this special population is still needed. Those interested in learning more about the complexities involved in treating this diverse group of offenders are referred to the 1988 NIC manual edited by Schwartz and Cellini. It provides a comprehensive overview of the problem along with state-of-the-art treatment modalities and discussion of model programs in correctional facilities.

4. Substance Abusers

Many of the problems identified in conjunction with treating sex offenders in prison are true of substance abusers as well. Professionals do not agree on the etiology of the behavior or the selection of treatment modalities, and the efficacy of such programs within correctional facilities has not been demonstrated. Further, outcome evaluations using recidivism as a measure are subject to the same methodological difficulties noted above.

Compounding these problems is the fact that it is hard to find many prisoners who are not substance abusers. The National Institute of Justice's (NIJ) *1989 Drug Use Forecasting Annual Report* stated that the percentage of males testing positive for one or more drugs at the time of arrest in 22 cities ranged from 53 to 83 percent. For females arrestees, the range was from 45 to 83 percent, and about 20 percent of both sexes tested positive for two or more drugs.[107] Among state prisoners, Chaiken (1989b: 1) determined that "...62 percent of prisoners reported using illicit drugs regularly before incarceration and 35 percent used major drugs" (defined as heroin, methadone, cocaine, LSD or PCP). This translates into literally hundreds of thousands of prisoners and still may be underestimated since this survey relied on self-reported behavior. Further, the prevalence of alcohol abuse was not reported.

Given the magnitude of need, it is not surprising that most substance abusers receive no treatment for this problem while incarcerated. Chaiken noted that in 1987, only about 11 percent of inmates were enrolled in drug treatment programs, although most DOCs provide some services to some substance abusers.[108] A few DOCs have residential-type treatment programs for the more severe substance abusers. For example, Delaware has *The Key* program,[109] Oregon has the *Cornerstone* program and New York has *Stay'n Out.*[110] Others offer educational information or self-help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous) to interested offenders; however, almost no one has a systematic treatment program designed to reach all substance abusers in the DOC.

One exception to the above is a program initiated by the Illinois Department of Corrections (IDOC). The IDOC has a comprehensive plan for substance abuse services that includes:

- initial assessment of substance abuse problems at all reception centers;
- provision of substance abuse education at all facilities by trained substance abuse educators;
- self-help programs at all adult facilities;
- residential treatment units at four male, one female and one juvenile institution;
- intensive outpatient treatment programs at three facilities; and
- special programs for inmates who are both mentally ill and substance abusers at one female treatment center and one male psychiatric center.[111]

Clearly, there is a need to address the problem of substance use and abuse among prisoners. Most correctional administrators acknowledge the link between substance abuse and crime, but not all are convinced that it is their responsibility to help find a solution. The "decline of the rehabilitative ideal" as a purpose of prisons found favor during the 1970s and '80s. This stance has been largely supported by the courts, which have consistently rejected prisoners' claims of a right to rehabilitation or to treatment for substance abuse while incarcerated.[112] A prisoner in need of medical attention for a problem associated with substance abuse (e.g., overdose, withdrawal) must be provided with appropriate treatment; however, these occurrences are rare in prisons. By the time most offenders arrive at the DOC's reception center, they no longer need medical attention for substance abuse. Detoxification has occurred at the county jail or another community facility.

While rehabilitation of substance abusers in prisons may not be mandatory, correctional administrators would do well to consider expanding their efforts. A comprehensive program for substance abuse services in prisons could have important long-term benefits for the criminal justice system as a whole and holds some promise for reducing the rate of substance abusers returning to prison.[113]

5. The Mentally Retarded Offender

Among the general population, estimates of the number of retarded citizens range from one to three percent.[114] Among prisoners, McCarthy's survey of state and federal corrections departments revealed an average of 2.5 percent of all offenders were classified as retarded, but the range was from zero to over 38 percent in specific DOCs.[115] Using published incidence studies of mental retardation among juvenile offenders, the National Center for State Courts arrived at a weighted prevalence of 12.6 percent.[116] For adult offenders, Santamour (1989) suggests that the prevalence of mental retardation is between four and nine percent.

Part of the variation in prevalence rates may be attributable to differences in defining mental retardation. Coffey *et al.* (1989) suggest that there are well-accepted definitions for the terms *mental retardation, developmentally disabled, learning disabled* and *learning disadvantaged* and that these terms should not be used interchangeably. The focus here is solely on the retarded, since as a group, they are most closely associated with special health needs.[117]

Like the physically handicapped, the needs of the retarded offender cut across several program lines. Planning for this group should include representatives from custody staff, social services, special education, vocational programs, prison industries and recreational services in addition to mental health staff. Traditional responsibilities of the latter include administration of intelligence and psychological tests to diagnose retardation,[118] and the development of individual habilitation plans for offenders who meet the definition of retardation.[119] Case management is a useful approach for this group of offenders.

Mental health counselors also can assist retarded offenders to accept the limitations of their conditions and to develop constructive ways of dealing with their anger and frustration. Many of the retarded have difficulty adapting to the prison environment and may become management problems. They are more likely than non-retarded offenders to be charged with disciplinary offenses -- sometimes because they do not understand the rules and sometimes because of their inappropriate behavior.[120] Santamour suggests that retarded offenders can benefit from both individual supportive counseling and group problem-solving activities.[121] There are several model programs for the retarded offender noted in the literature including those offered by DOCs in California,[122] Georgia,[123] Nebraska,[124] South Carolina[125] and Texas.[126]

At a minimum, every DOC must take steps to assure the physical safety of the retarded and their "freedom from undue restraint."[127] Retarded offenders are highly susceptible to victimization by other inmates that can range from co-opting their commissary items to sexual misconduct. As a consequence, some type of protective housing is needed. Professionals differ as to whether segregated institutions, segregated housing or mainstreaming the retarded as much as possible is the best approach to managing them within prisons.[128] Regardless of the approach taken, housing decisions for retarded offenders must take into account their special need for personal safety.

D. Conclusions

The preceding discussion helps to illustrate the wide variety of offenders with special health requirements and underscores the necessity of careful

planning to address those needs. Much of the material focuses on in-prison programming. More global approaches to special needs offenders would emphasize alternatives to incarceration, changes in sentencing guidelines, and more judicious use of compassionate release programs. While DOC personnel are encouraged to work with state legislators and other appropriate individuals to effect such changes, like the poor, the special needs offender will always be with us. In fact, if current trends are not reversed, the cost of caring for offenders with special needs is likely to overwhelm many DOCs' budgets in the future.

In examining the various special health needs of offenders, there was one common theme. Almost without exception, national incidence and prevalence data were lacking. More important -- at least in terms of its potential impact on specific DOCs -- good data often were not available at the state level either. In the absence of specific information on the extent and level of current needs, it is impossible to plan for what many believe to be the coming crisis for corrections; namely, many more inmates who are older, sicker and staying longer to be housed and cared for in institutions whose resources already are stretched to the limit. The need for accurate data in planning correctional health facilities is examined further in Chapter X, and data management and documentation are the focus of Chapter XI as well.

ENDNOTES

1. See Austin & McVey (1989: 4-5).
2. See e.g., McCarthy and Langworthy, eds. (1989).
3. See Austin & McVey (1989).
4. Under the direction of Ronald Shansky, MD, the health services section of the Illinois Department of Corrections conducted a survey in 1990 of the 50 state departments of correction to identify their special needs populations. Only about three fifths of the DOCs responded and many were not able to provide actual data for several of the categories listed.
5. Annual reports on AIDS have been published by the National Institute of Justice since 1986. The fourth report was released in 1990. See Moini and Hammett.
6. It should be noted that all housing recommendations are based on medical need without regard to the patients' custody classifications.
7. The NIC's National Academy of Corrections has a training package entitled "A Systems Approach to Managing Chronically Ill Inmates (in the Criminal Justice System)" that may be of assistance in planning for special needs offenders. Contact:

The NIC Information Center
1790 30th Street, Suite 130
Boulder, CO 80301
303/939-8877

8. In prisons, non-natural causes of death such as accidents, homicides and suicides may well exceed specific natural causes. Published studies of prisoner mortality rates are virtually non-existent. An article by King and Whitman (1981) identified only three such studies and the two for prisons were both for very limited time periods (i.e., one or two years). More promising is a recent mortality study of deaths in the Maryland prison system over a nine year time period (1979-1987). These data showed that the leading cause of death was circulatory system disease, followed by suicide and then "homicides and legal intervention." The latter term, presumably, is a euphemism for executions and other deaths caused by the state (e.g., killing an escapee). See Salive *et al.* (1990).
9. Again, good data are not available for state prisoners, although there have been a handful of studies of hypertension among jail populations (see e.g., Raba and Obis, 1983; and Smirnoff and Keith, 1983). In the general U.S population, it is known that the prevalence of hypertension among blacks is about twice as high as that for whites. Owing to the disproportionate number of blacks in U.S. prisons, it can be inferred that "significant numbers of inmates are hypertensive."
10. TDCJ's "Health Summary for Classification" form lists some of the items to be considered in housing and program assignments for offenders with special health needs. See Appendix A.
11. See Eichold (1989).
12. The American Diabetes Association (ADA) has established guidelines for health providers in managing diabetes. A position statement entitled "Management of diabetes in correctional institutions" is available to practitioners without charge. The ADA also has a health education pamphlet for prisoners entitled "The prison inmate with diabetes: what you need to know." Both of these publications can be obtained from:

American Diabetes Association
1660 Duke Street
Alexandria, VA 22314
703/549-1500

13. See Rieder *et al.* (1989).
14. *Ibid.*, p. 388.
15. See Selwyn *et al.* (1989).
16. See Moini and Hammett (1990).
17. Braun *et al.* (1989).
18. See Chapter IX, section C.
19. For example, Ronald M. Shansky, MD; Armond H. Start, MD.
20. See the following publications and the references cited therein: King and Desai (1979); King and Whitman (1981); Healton (1981); and Coleman *et al.* (1984).
21. See King & Desai (1979); and Healton (1981).
22. King and Desai (1979) provide some basic guidelines on the diagnosis and management of patients with epilepsy that may be useful.
23. See Coleman *et al.* (1984).
24. In their survey of the Illinois prison system, Coleman *et al.* found that many correctional officers still believed it was appropriate to "assist" people having seizures by placing something in their mouth or by restraining them or by moving them. The Epilepsy Foundation of America (EFA) offers a number of publications that provide up-to-date information on the etiology and management of seizure disorders. Contact:

EFA's National Epilepsy Library and Resource Center
4351 Garden City Drive
Landover, MD 20785
301/459-3700

25. See Chapter IX, sections C.1. and D.4.b. and the references cited therein.
26. In 1990, medications alone were averaging about $3,000 annually per patient for AZT and about $4,000 annually per patient for aerosolized pentamidine. Add to this the cost of more staff in-house, the charges of AIDS specialists and the cost of sometimes lengthy hospital stays and it is easy to see why caring for AIDS patients is overwhelming some DOCs' budgets.
27. The Commission's 1990 policy statement on the administrative management of inmates who are HIV positive or who have AIDS is reproduced in its entirety in Appendix I. To keep pace with clinical developments, the NCCHC's board reviews this policy statement every six months. Interested individuals should contact NCCHC for current updates to its policy statement.
28. See Resnick and Shaw (1980). Although a number of their comments are politically biased and some of their conclusions are naive or impractical, the section on incarcerated women's health needs is worth reviewing. As with men, there is little epidemiological information in the literature on women prisoners except for AIDS and the special needs of females such as abortion and pregnancy. For listings of articles on females offenders and their health needs, see the bibliographies by the National Library of Medicine (1990) and the ACLU's National Prison Project (1985). For general discussions of health services for women offenders, see Brecher and Della Penna (1975); Dubler (1986); and McGaha (1987).
29. There are still a number of correctional facilities housing females that prohibit the use of tampons "for security reasons." The usual explanation is that tampons can be used to hide drugs or for purposes of masturbation or homosexual activity. This is nonsense. Prohibiting tampons will not deter any of these activities, since the tampon is not a necessary component of any of them.
30. This is consistent with requirements of ACA's standards (1990: 130); APHA's standards (Dubler, 1986); and NCCHC's standards (1987: 40). See also Chapter III on the legal issues surrounding abortion for prisoners.
31. See Dubler (1986: 7).
32. See Baunach (1985: 1).
33. For a discussion of these and other issues on mothers in prison and some policy recommendations, see Baunach (1985).
34. See e.g., U.S. General Accounting Office (1979); U.S. Comptroller General (1980); Pennsylvania Prison Society (1983); and Rafter (1985).
35. See Dale (1990) and Rafter (1990).
36. See Hall (1990).
37. *Ibid.*, p. 11.
38. The Texas Department of Criminal Justice (TDCJ) uses a case management approach in its Physically Handicapped Offender Program. For copies of the plan, policy manual and sample forms, contact:

Barbara Swift
Physically Handicapped Offender Program
Texas Department of Criminal Justice
P.O. Box 99
Huntsville, TX 77342-0099
409/295-6371

39. The "Americans with Disabilities Act of 1990," Public Law #101-336 was signed into law by President Bush in August of 1990.
40. Difficulty communicating complicates the diagnostic process. Additionally, interpreters

sometimes embellish or distort the information from the patient. Accurate diagnosis of mental problems is particularly difficult, since gestures and body movements may be misinterpreted and many diagnoses rely on the pattern of verbal expressions. For more information, see Parwatikar *et al.* (1990).

41. Austin and McVey (1989: 5).
42. See Burnett (1989).
43. See Walsh (1989: 217).
44. See Sapp (1989: 20) and the references cited therein. Also see Walsh (1989).
45. Walsh (1989: 218).
46. See comments of Ken Peterson, RN as noted in the Correctional Law Reporter (1990: 58); personal communication with Ronald M. Shansky, MD, 1990.
47. See Hall (1990: 9).
48. Baer (1989: 5).
49. Moore (1989: 185-186).
50. For a fuller discussion of age-related changes, see Booth (1989), especially pp. 199-206.
51. See Moore (1989).
52. As cited in Baer (1989: 5).
53. Initiated by Professor Jonathan Turley, POPS seeks early release of elderly offenders based on their infirm condition and low risk of recidivism. See NCCHC, 4 **CorrectCare** 4: 1 (1990).
54. Hall (1990: 12).
55. A good case can be made for allowing terminally ill inmates to have access to experimental drugs and therapies. See the discussions on therapeutic trials in Chapters III and IV.
56. See Gross (1990: 12).
57. *Ibid.*, p.14.
58. *Ibid.*, p. 13.
59. See TDCJ (1989).
60. Unfortunately, the TDCJ survey did not list the names of the 40 states responding, so it is not possible to determine whether more states initiated compassionate release programs between 1988 and 1990 or were part of the ten states that did not respond to the TDCJ survey.
61. See Hall (1990: 10).
62. California, Florida, New Jersey, New York and Texas.
63. The New Jersey Governor's office had granted "one or two applications for executive clemency" to prisoners with AIDS over a five year period. The Texas Governor's office approved 40% of the 145 applications for emergency medical reprieves during 1987 through March of 1990, some of which were for prisoners with AIDS. The New York Governor's office -- in spite of a 17-20% HIV seropositive rate and 920 AIDS deaths since 1981 in the DOC -- had not approved a single application for executive clemency for prisoners with AIDS. For more information, see the report by the Correctional Association of New York (1990).
64. The Texas Department of Criminal Justice has done a commendable job in researching the options of alternative care settings for an array of special needs offenders. See TDCJ (1989).
65. Kim Thorburn, MD has written an excellent article on the medical management of self-mutilation in prisons. See Thorburn (1984).
66. See Chapter VII, section C.3.
67. Mental health programs in the following DOCs were reviewed: Maryland, New York, South Carolina, South Dakota, Texas and Vermont.
68. From Quijano (1990: 6).
69. *Ibid.*, p. 14.
70. As Doctor Quijano notes, other protocols for managing self-mutilating inmates are available. The Georgia Department of Corrections uses the same protocol for all of its self-mutilators regardless of the inmates' motivation. For a copy of this protocol, contact:

    Georgia Department of Corrections
    Mental Health/Mental Retardation Services
    Floyd Veterans Memorial Building
    Room 756-East Tower
    2 Martin Luther King Drive, SE
    Atlanta, GA 30334

71. Doctor Quijano has prepared a bibliography on self-mutilation and explosive disorders to accompany his comments. It is included in a special section of the references listed at the end of this chapter.
72. See TDCJ (1990: 11).
73. *Ibid.* For copies of the plan, sample forms and policies and procedures, contact:

    Charles Alexander, MD
    Deputy Director for Health Services
    Texas Department of Criminal Justice
    P.O. Box 99
    Huntsville, TX 77340
    409/294-2932

74. See e.g., Danto ed. (1973) and the articles contained therein. Also see the bibliographical listings contained in Hayes and Rowan (1988) and the special issues on jail suicide in Volume 60 of the *Psychiatric Quarterly*, 1989.
75. See Hayes and Kajdan (1981) and Hayes and Rowan (1988).
76. Anno (1985).
77. Salive *et al.* (1989).

78. This finding is consistent with the general literature on suicides in the community. For an interesting discussion of why black suicide rates are lower than white suicide rates, see Griffith and Bell (1989).
79. Anno (1985: 87-88) reported a range of time served at the point of suicide from six days to over five years. Half of the victims had served a year or less of their sentences and half had served over a year. Salive *et al.* (1989: 367) reported a range of time served from less than one month to more than 180 months. It should be noted that these findings are very different than those reported in studies of jail suicides where the majority suicide within 24 hours of confinement. See Hayes and Kajdan (1981) and Hayes and Rowan (1988).
80. Anno (1985) reported 89% of the 38 Texas victims died from hanging and Salive *et al.* (1989) found that 86% of the 37 Maryland suicides were by hanging. Other methods reported in both studies included cutting, drug overdoses and falls from heights.
81. These factors were not examined in the Maryland study.
82. The Bureau of Justice Statistics (BJS) published a table (#6.72) in its 1987 *Sourcebook of Criminal Justice Statistics* on cause of death among state and federal prisoners. The data, however, underreport suicide. For example, BJS data show four suicides in Maryland prisons in 1986 while Salive *et al.* reported six. Also, data were not available for the Texas prison system.
83. See Anno (1985).
84. See Chapter VII, section C.2.
85. See Anno (1985); and Salive *et al.* (1989).
86. See Anno (1985); and Kennedy and Homant (1988).
87. For additional guidelines, see Schuster (1979); and Atlas (1989).
88. Salive *et al.* (1989: 367) found that maximum security inmates had a relative risk of suicide that was 5.1 times that of inmates in other types of institutions.
89. Most of these elements are addressed further in NCCHC's essential standard P-58 on suicide prevention. See NCCHC (1987: 38-39).
90. NIC has published a training manual on suicide prevention for jail detention officers that can be of assistance. While some of it does not apply to prison suicides (e.g., the profile data), much of the advice is useful for suicide awareness training and can be adapted to the prison setting. See Rowan and Hayes (1988).
91. A sample policy statement and observation checklist from TDCJ are provided in Appendix H.
92. It should be clear that placing an inmate in a psychiatric observation cell is a temporary measure and is not intended to be a lengthy or permanent housing assignment.
93. Guidelines for conducting a psychological autopsy are reviewed in Spellman and Heyne (1989).
94. For a discussion of legal liability in custodial suicides, see O'Leary (1989). See also Cohen (1988).
95. See e.g., Brecher (1978); Schwartz ed. and Cellini (1988); and the special volumes of the Pennsylvania Prison Society's *The Prison Journal* dated Fall-Winter 1988, Spring-Summer 1989 and Fall-Winter 1989.
96. From Contact Center, Inc.'s *Corrections Compendium* dated May 1987, as cited in Schwartz ed. and Cellini (1988: 1).
97. See Bureau of Justice Statistics (1987: 491).
98. *Op. cit.* in endnote 92.
99. Vaughn and Sapp (1989: 79-82).
100. See e.g., Daane (1989); Darnell (1989); Jenkins and Katkin (1989); and McKenna (1989).
101. See Vaughn and Sapp (1989: 77-78).
102. See Schwartz ed. and Cellini (1988).
103. See Dougher (1988).
104. See Green (1988).
105. Smith (1988: 31).
106. Schwartz ed. and Cellini (1988: 2) reported that 46 states offered at least group therapy while a number had "highly sophisticated, multi-modality programs." Appendix F of that same publication described model programs in 24 DOCs. What was most striking to this author was that almost none of the model programs appeared to have evaluation components to measure their effectiveness.
107. See NIJ (1990: 2).
108. Chaiken (1989b).
109. See Hooper and Wald (1990).
110. See Chaiken (1989a).
111. For more information about the Illinois DOC's substance abuse services, contact:

Anthony T. Schaab, PhD
Chief of Mental Health Services
IDOC
4-200 State of Illinois Center
100 W. Randolph Street
Chicago, IL 60601
312/814-3017

112. For a legal analysis, see Cohen (1988: 107-111).
113. Chaiken (1989a) provides an in-depth look at the success of in-prison programs for drug abusers.

114. See Santamour and West (1977); Coffey *et al.* (1989); and Santamour (1989).
115. McCarthy (1985: 18).
116. As reported in Coffey *et al.* (1989).
117. In addition to the retarded, substantial numbers of inmates have learning disabilities or are functionally illiterate. One study reported in Coffey *et al.* (1989: 21) found that 42% of inmates were learning disabled. The problems of these latter groups, however, are largely the province of the DOCs' education divisions.
118. NCCHC's standards (1987: 25) mandate that all inmates be screened for mental retardation within 14 days of their admission to the prison system.
119. The most widely accepted definition of mental retardation includes three components:

1) the person must test subaverage in intellectual functioning (and not as a result of cultural, educational or language deprivations) as determined by an individually administered standardized intelligence test; and

2) s/he also must show impairment in adaptive skills (e.g., personal hygiene, feeding, working, socializing) not commensurate with age; and

3) these disabilities must have manifested themselves before the person reached 18 years of age.

For more specific information, see Coffey *et al.* (1989). Also, see Hall (1985) on the problems of identifying and serving the retarded in prison.

120. See Santamour and West (1977); and Coffey *et al.* (1989).
121. Santamour (1989).
122. See Kramer (1986); and Coffey *et al.* (1989).
123. See Hall (1985); and Coffey *et al.* (1989).
124. See Morton *et al.* (1986); and Coffey *et al.* (1989).
125. See Coffey *et al.* (1989).
126. See Pugh (1986); and Santamour (1989).
127. See Cohen (1988: 124-131).
128. See the discussion in Rideau and Sinclair (1983: 109-111).

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CHAPTER IX

HEALTH PROMOTION AND DISEASE PREVENTION

A. Introduction

The purpose of this chapter is to acquaint the reader with important concepts, standards and strategies for developing and maintaining programs in the areas of environmental health and safety, communicable disease and infection control, and health education. There is some overlap of the information contained within each of these sections. Developing and implementing successful programs in these three areas can result in numerous positive outcomes for the institution or agency willing to invest the necessary time and effort. In the long run, successful programs in each of these areas not only will provide savings to the taxpayer, but also will allow administrators to manage their institutions more effectively. Additionally, many believe that effective programming in these three areas is an important contribution of the health care program to the potential rehabilitation of the committed offender.

Good environmental health and safety programs prevent accidents and injuries, thus diminishing medical expenditures and protecting against avoidable litigation. In addition, such programs enable institutions to utilize their scarce material resources as effectively as possible. To the extent that suitable communicable disease and infection control programs are implemented, disease spread is minimized, medical as well as litigation expenditures are reduced and equally important, medical and correctional staff develop professionally appropriate attitudes and skills. This clearly results in a more competent and, therefore, self-confident correctional staff.

Finally, by initiating a health education program as part of the strategy to create a safe and healthier environment, an institution can enhance its ability to reduce long-term medical expenditures. Through the use of intake screening for communicable diseases, and education programs that are disease specific (such as for AIDS), both inmates and staff can participate in creating a healthier environment. Through the use of chronic clinics for illnesses such as hypertension, diabetes, tuberculosis, asthma and seizure disorders, and specific educational programs designed for each of these chronic illnesses, the health care staff may contribute to empowering inmates with the knowledge to enhance their long-term health and well-being.

A knowledgeable administrator will appreciate the long-term benefits to be gained from the initial investment in staff, training and necessary equipment required to develop effective programming in these areas. Policy guidelines should be developed by the health services central office, which retains professionals who have the requisite technical knowledge. Once these policies have been promulgated, procedures for implementation should be developed, taking into account the uniqueness of each institution. With a combination of written policies and procedures coupled with initial and on-going training programs for both medical and non-medical staff, institutions can ensure that they remain up-to-date in their management practices.

B. Environmental Health and Safety

A safe and sanitary environment is fundamental to public health. For the incarcerated, it is also a constitutional right since inadequate prison conditions have been judged to be in violation of the Eighth Amendment (see Chapter III). The need for a comprehensive and effective environmental health program in corrections is crucial, especially at a time when prison crowding is the rule rather than the exception. A prison population in excess of design capacity affects not only the quality of housing, but also places pressure on all areas of administration and operation of the institution, especially the health program. Crowding is a major factor in increasing the risk of disease transmission, accidental injury and violence. While crowding cannot be condoned, when it occurs its potential adverse effects on health must

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This chapter was developed by Judy Coe, Peter Kwasnik and Ronald M. Shansky.

be minimized in accordance with the rules and principles of community hygiene and safety.

1. Administration

The environmental health and safety program should be part of the health services system recommended in Chapter V to be sure that it is included in a comprehensive health plan that coordinates clinical efforts with disease and accident prevention measures. It should not be part of a risk management program, since there is a distinct philosophical difference between loss prevention and health maintenance. In risk management, economic issues may skew program emphasis and direction, and may result in sidestepping the underlying health and safety issues.

The statewide program should be managed by an individual with education and experience in the multi-disciplinary field of institutional environmental health and safety. Ideally, this individual should be a registered sanitarian[1] and a certified safety professional.[2] The environmental health program manager serves as a technical consultant to unit personnel and should be capable of planning, developing, organizing and directing the systemwide environmental health and safety program. S/he is responsible for promulgating and monitoring policies and directives that reflect all applicable laws, rules and regulations, as well as national consensus standards[3], which are designed to assist in achieving accreditation by the American Correctional Association (ACA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the National Commission on Correctional Health Care (NCCHC). The responsibility for program implementation should be at the institutional level, since it is the chief administrative officer (warden) who has the authority to control practices and conditions.

The environmental health and safety program manager should report directly to the statewide health services director (HSD) and have line authority over any professional program staff who work for health services. If the unit sanitarians are on the custody staff, the statewide program manager should provide training and monitor their activities. A working relationship with the chief administrative officers of the institutions is required in any case. The statewide environmental program manager should have involvement in the budget process to accommodate and prioritize funding for environmental health and safety programs, and for projects that are dictated by need, legal requirements and societal expectations. Ideally, each institution should employ registered sanitarians; however, if not in conflict with the sanitarian registration laws of the state, trained technicians under the technical direction of the statewide environmental program manager can fulfill this function.[4]

2. Food Service Sanitation

For the incarcerated, mealtime is probably one of the more significant events in the routine of prison life. How food tastes, its appearance and presentation, and the conditions under which it is served can affect the mood as well as the health of an entire institution. People expect to be served food that is wholesome, appetizing and safe to eat. This expectation may have greater validity for the incarcerated than for the general public as the inmate has little choice as to where or what s/he eats. Therefore, obvious disregard for food service sanitation can result not only in foodborne disease outbreaks, but also may lead to generalized discontent and unrest in the prison.

Compliance with national and local food service sanitation standards is essential to ensure that food is safe for human consumption. The 1976 Model Food Services Sanitation Ordinance, as published by the U.S. Public Health Service, Food and Drug Administration, is the basis for all food service sanitation standards (including those of the NCCHC, ACA and APHA).[5] Its criteria should be used for the food protection program in corrections and for vendors serving correctional institutions.[6] This program should include a system of monitoring compliance with sanitation standards at a frequency specified by ACA, NCCHC or APHA.[7]

The food protection program must be comprehensive and include all areas where food is stored, prepared, served, transported or consumed. Sanitation issues relating to commissary items, religious diets and sack lunches should not be overlooked. Particularly, a system of controls should be in place that will protect food from all sources of contamination, maintain potentially hazardous food at appropriate temperatures (e.g., foods containing proteins must be kept at temperatures below 45° F or above 140° F.) and promote and ensure hygienic practices of food handlers. Regular monitoring of food delivered to lockdown or other remote areas should be implemented. Food temperatures should

be logged both at the time food leaves the kitchen and when it is served in the remote areas. Improper temperature control of food sent to remote areas is one of the most common prison food service deficiencies.

Routine physical examinations of food handlers (including TB skin tests and serologic tests for hepatitis and syphilis) provide little, if any, benefit in the prevention of foodborne diseases. These should be required only in those states where they are mandated by public health laws.[8] Otherwise, they are not necessary for food service work. A better medical clearance method for food service personnel is to conduct medical record reviews to look for seizure disorders, history of foodborne illness and current infections, and conduct visual inspections for skin lesions.[9] Training staff and inmate workers in the principles of food service sanitation and proper supervision are more meaningful in disease prevention than routine exams.

Also recommended is certification in sanitation for all food services supervisory personnel.[10] The quality of a food service operation is dependent on the professionalism of its staff. Supervisory personnel must have training and experience in mass food production. The dietary manager should have formal training in nutrition and dietetics and have at least one year of professional experience in food service management. Promoting untrained correctional staff to dietary positions is not recommended.

It is important that inmate workers have the commitment and desire to work in food service. If institutional dietary work assignments are relatively well paid, inmate workers will be more inclined to be productive and dependable. If these assignments are involuntary or without incentives, the work crew may be difficult to manage and may engage in activities that are detrimental to food safety.

3. Vector Control

Each facility should have a pest control program for managing, if not eliminating, vectors of disease.[11] In order to be successful, the program must emphasize environmental rather than chemical controls. Good housekeeping is essential for controlling pests by denying them food, shelter and a medium for breeding. Food should be stored in a manner that is inaccessible to insects and rodents. Trash must be stored in covered containers and in areas that are kept clean. Supplies should be stored neatly, above the floor/ground and in a manner so as not to serve as a nesting site for vermin.[12]

Physical barriers should be utilized to prevent the entrance of pests. All openable windows require intact screens. Entrances with doors that are normally kept open for prolonged periods of time should be protected with air curtains or screen doors. Cracks and other openings that lead to the outside and that are larger than ¼ inch should be eliminated.

Whenever possible, existing insect, bird and rodent infestations should be eliminated by means other than the use of poisons. Traps and electrocution devices are generally safer than chemical agents. When pesticides are used, however, they must be applied intelligently and in accordance with federal and state laws.[13]

Pest control services may be more economical if performed by a staff pest control technician. A contractual operator usually requires the accompaniment of a staff member for reasons of key control and other security issues. This significantly impacts on the cost of the service. An in-house pest control program may prove to be more effective because of the technician's familiarity with the facility and its operation. S/he also may be more inclined to employ environmental controls in dealing with pest problems.

Correctional facilities should have a written pest control plan that identifies the pesticides that are used and requires records of where and when they are applied.[14] In addition, it should contain policies and procedures for handling parasite-infested laundry and environments.

4. Air Quality

Indoor air pollutants have been linked to acute and chronic lung disease. The hazards of molds, airborne asbestos fibers, cotton and other dusts, and volatile hydrocarbons are well known. More recently, passive inhalation of tobacco smoke has been recognized as a health issue in corrections. It is essential that indoor air pollution be minimized by means of engineering and administrative controls. Mechanical ventilation in housing units should conform to ACA and APHA standards.[15] Driers and shower areas must be vented to the outside. Work place exposure to airborne contaminants should meet standards of the Occupational Safety and Health Administration.

There should be routine monitoring of ventilation systems and, if necessary, air quality.

Sources of air contamination must be eliminated. The facility should have a policy designating smoking and non-smoking environments,[16] applicable to both staff and inmates.

5. Water Supply and Sewage Disposal

The water supply must be safe for human consumption and adequate to meet the need of the correctional facility and for fire-fighting purposes.[17] The treatment of water, its quality and distribution should meet all applicable federal and state laws, rules and regulations.[18]

Each institution should employ qualified plumbers not only to maintain, modify and expand the water distribution system, but also to identify and correct any condition that has the potential for adversely affecting water quality and availability.[19]

Plumbing fixtures should be installed to conform with local plumbing codes. They should be in sufficient numbers, accessible, with adequate water pressure, and kept clean and in good repair.[20] A sufficient number of toilets, drinking fountains, handwashing sinks and shower facilities must be available for the physically handicapped.[21] Hot water for showers should be thermostatically controlled at temperatures between 100° and 120° Fahrenheit.[22] Temperatures below 100° F are uncomfortable for bathing and may deter good hygiene practices. Water temperatures above 120° F may cause scalding. Special populations, such as the mentally retarded and mentally ill, may require additional precautions (e.g., water temperatures no higher than 110 degrees).

Handwashing sinks should be provided with combination faucets. Self-closing, slow closing or metering faucets should provide a flow of water for at least 10 seconds.[23]

The waste water systems must conform with applicable federal and local laws, rules and regulations.[24] Sewage (including mop water and wastes from other wet cleaning processes) must be disposed of by means of a sanitary sewer. There should be a system for draining tunnels, basements and similar areas to prevent water from accumulating.

6. Lighting

Sufficient levels of illumination are necessary in all areas used by inmates, visitors and staff for reasons of security and to enable them to engage in activities safely and efficiently.

Good lighting is generally a design consideration utilizing natural and artificial illumination. A source of natural light should be provided for all inmate rooms and cells as well as inpatient areas. Windows should be approximately 10 percent of the floor area in size, but not less than three square feet.[25]

The amount of artificial illumination that is necessary is dependent upon the task, the size and configuration of the room or area, and the texture and color of finishes.[26] Light fixtures should be of a type and spaced in a way that will not cause glare or troublesome shadows. These fixtures should be kept clean, in good repair and free of obstructions that may adversely affect the quantity and quality of illumination.

There are numerous standards that quantify illumination for various tasks and conditions. As a rule, these standards require general illumination of two to ten footcandles on walking surfaces and in storage areas, 20 to 30 footcandles in general services areas and 50 to 60 footcandles for specific industrial tasks. Local illumination for invasive medical and dental procedures should be at least 200 footcandles. It is recommended that correctional institutions conform to the more stringent illumination requirements of ACA and APHA.[27]

7. Noise Control

Exposure to excessive levels of noise can adversely affect health, safety and the morale of inmates and staff. Too much noise is irritating and may be the cause of stress and even hearing loss. Therefore, acoustical considerations play an important part in the correctional environment.

Engineering controls to limit noise transmission should be part of the original design or retrofit of the facility. These should include sound barriers (doors, walls, partitions, etc.) and noise dampers (acoustical tiles, carpeting, etc.) to limit background noise to acceptable levels. Owing to the unusual nature of correctional institutions, particularly those of older design, such engineering controls often are insufficient and must be augmented with administrative controls.

Televisions and radios for communal use should be located in rooms or areas that will not disturb resting or sleeping inmates. Volume controls should be governed to acceptable levels of that particular area. Inmate-owned televisions and radios should be equipped and used with headsets. Housekeeping

activities and non-emergency repair should be scheduled during normal working hours and utilize equipment that is designed and maintained for quiet operation. If possible, inmates with assignments during off hours should be afforded separate housing to accommodate their work-sleep regimen.

The American Correctional Association recommends noise levels in inmate housing units not exceed 70 dBA during the day and 45 dBA at night.[28] However, efforts should be made to limit background noise in sleeping areas to 35 dBA with occasional sound levels up to 45 dBA and rare peaks of 55 dBA.[29] This also applies to health care facilities, libraries and places used for meditation. For occupational noise exposure, OSHA standards provide permissible noise exposure and criteria for an effective hearing conservation program.[30]

8. Housekeeping

A clean and orderly environment is important for reasons of health, safety and aesthetics. A clean facility is less likely to have problems with pests and accidental injuries and may have a positive impact on attitudes and morale. The facility should have a comprehensive housekeeping plan that identifies what has to be cleaned, at what frequency, by whom, how it is to be cleaned and who evaluates cleaning effectiveness.[31] The self-inspection process should be critical and in accordance with ACA, APHA and NCCHC standards.[32]

Sufficient and appropriate cleaning equipment and supplies should be made available for use throughout the institution.[33] Water-soluble cleaning compounds should be used and should not be mixed with anything other than water. They must be kept in labeled containers and stored in a safe, secure manner away from food products. Workers should be made aware of any and all hazards associated with the cleaning supplies they use by means of material safety data sheets and training.

Cleaning, buffing and stripping should employ procedures, supplies and equipment to minimize the generation of airborne dust. Common use fixtures (drinking fountain, sinks etc.) must be sanitized at a frequency that is dictated by use. Shower floors, wall and seats must be cleaned and disinfected after each session of use.

The health care unit should have policies and procedures for cleaning clinical areas and fixtures, and for decontaminating environmental surfaces soiled with blood and other bodily excretions and secretions. Beds and bedside furnishings should be thoroughly cleaned and disinfected immediately after discharging the patient. Biological monitoring (e.g., culture of environmental surfaces) is not recommended other than for educational purposes.

a. Laundry

Laundry services should ensure the availability of a sufficient supply of clean linen and clothing. Each inmate should be provided with at least three clean changes of clothing per week;[34] preferably one clean set of clothing each day. Bed linen and towels should be changed and laundered at least weekly.[35] More frequent bedding and clothing changes are required for incontinent and enuretic inmates as well as for inmates with special clothing needs based on their work assignments.

Laundry services should be provided by an in-house central laundry or a contractual commercial linen service, augmented with self-service washers and driers whenever possible.[36] The in-house central laundry should be operated with consideration for worker safety and health. Laundry soiled with human excretions and secretions may become a source for spreading infectious diseases. Individuals assigned to soiled laundry-handling activities should wear gloves, aprons, smocks or other protective garb and maintain high standards of personal hygiene. Laundry known to be infectious or parasite-infested requires special handling. It should be double bagged at the point of collection, using a water soluble inner bag. The outer bag should be labeled or otherwise made identifiable as infectious laundry. Such laundry should be rendered safe by machine washing at temperatures at or above 160° F for twenty minutes or by any other method approved by the health authority.[37]

Clean linen and clothing should be protected from all sources of contamination. The central laundry should ensure physical and procedural separation of clean and soiled laundry activities. Clean laundry should be stored off the floor on clean surfaces in clean areas. Carts used for transporting linen should be clean, covered and used for no other purpose.

The in-house laundry should be supervised by an individual familiar with the equipment, supplies and processes of a commercial laundry operation as well as with the infection control policies and procedures of the institution or agency.

b. Barber and Beauty Shops

Barber and beauty shops should be operated in conformance with applicable laws, rules and regulations.[38] They should be located in an enclosed area used for no other purpose. Barber and beauty shops that share a common passage with sensitive service areas (e.g., dietary, commissary, laundry) should have self-closing doors that are kept shut when not in actual use.

Such operations should be provided with appropriate equipment and employ effective methods for disinfecting tools and instruments. Chemical disinfectants and ultraviolet lights should be changed at a predetermined frequency. It is important also to keep ultraviolet lights clean to maximize their effectiveness.

The use of razors (including electric ones), shaving brushes and mugs for more than one person should be prohibited.[39] Disposable straight razors should not be stropped as this practice could result in the indirect transmission of bloodborne diseases. Combs, brushes, shears and other tools should be disinfected between use and should never be carried in the pocket of the barber or cosmetologist.[40]

c. Health Care Facilities

The principles of safety and sanitation for correctional health care facilities are no different than those for hospitals. The extent of their applicability is dependent upon the services and care provided. A few correctional health facilities may qualify as full service hospitals and, therefore, should conform with the hospital licensing standards of the state.[41] Those that provide basically outpatient services should be required to meet the standards that apply to clinics or ambulatory care facilities.[42] In general, the environmental health and safety considerations for correctional health care facilities should be directed to expedite the recovery of the patient, prevent nosocomial infections and ensure a safe and sanitary physical plant, equipment and supplies.

Health care facilities should have infection control policies that cover written procedures for handwashing, housekeeping, decontamination, disinfection and sterilization of equipment and supplies, medical isolation, infectious and parasitic laundry, infectious waste, pest control and parasite-infested environments.[43]

Handwashing stations should be located in or convenient to treatment areas, nurses' stations, examination rooms, pharmacy, laundry, x-ray, laboratory, toilet rooms and other areas where handwashing is necessary. Handwashing sinks should have combination faucets or mixing valves that can be activated with foot, knee or wrist controls.[44] Smoking and the consumption of food and drink should be prohibited in all treatment areas, the pharmacy, all diagnostic facilities, anywhere oxygen is stored and used, and anywhere food, pharmaceuticals, clean linen, and clean and sterile supplies are stored.

Pharmaceuticals, food and all medical supplies should be stored in clean areas in a manner that protects them from contamination. They should be kept off the floor, on shelves, in cabinets or on appropriate dunnage racks or pallets. Such items should not be stored under sinks or under unprotected water and sewer lines. Food, pharmaceuticals, laboratory specimens, disinfectants and toxic, caustic, infectious or otherwise hazardous substances should be stored physically separate from each other.[45] Dated food, supplies and pharmaceuticals should be removed from stock at or prior to their expiration date.

The health care unit should be designed and equipped to accommodate the physically handicapped.[46] Audible and/or visual means for signaling nurses or for summoning help should be available at patient beds, in toilet rooms and bath areas. The signal activation mechanism should be within easy reach.[47]

Patient beds should have non-absorbent, flame resistant mattresses or mattress covers capable of being disinfected. Each bed should be accompanied with appropriate furniture for the orderly storage of personal belongings and to accommodate in-bed and out-of-bed dining.

Inpatients should be provided with clean bedding, i.e., pillow, pillow case, two sheets and, if necessary, draw sheets and blankets. Bed linens should be changed as often as is medically indicated or when climatic conditions dictate or when soiled. In no case should linen be used for more than one week or for more than one patient. After the patient is discharged, the bedframe, mattress and bedside furniture should be effectively cleaned and disinfected.

The health care unit should have a bio-medical electronics safety program that includes semi-annual checks of defibrilators, isolation transformers and other electric/electronic equipment. Such checks

should be performed by qualified technicians and documented.

9. Maintenance

Each facility should have a formal plan for maintenance.[48] It should include scheduled inspections and servicing of all heavy equipment (e.g., H/VAC, generators, kitchen equipment) and a schedule of inspection of the physical structure such as the roof, ceilings, rain gutters, and sewage and water systems. Monthly inspections should be conducted for sanitation and safety purposes, utilizing an inspection form. All deficits found should be entered on a work order and the maintenance department should provide a date for repair to the health and safety inspection officer. The warden of the facility should require a report of work deadlines not met in order to provide effective monitoring of repairs.

The maintenance program should be under the supervision of a qualified engineer or person with commensurate experience. S/he should have formal training in occupational safety and health and be familiar with the OSHA standards for General Industry (29CFR1910) and Construction Industry (29CFR1926). Maintenance and repairs should be made in accordance with applicable codes and regulations by qualified individuals.

The maintenance program must be effective in ensuring a safe, healthful and comfortable habitat. Structures should be kept weather-tight, vermin-proof and in good repair. Plumbing, electrical and mechanical systems and their appurtenances should be maintained in a safe and functioning condition. Walking surfaces should be kept free of trip and other hazards.

10. Waste Disposal

Refuse should be handled, stored and disposed in a safe and sanitary manner and in conformance with applicable laws, rules and regulations. A sufficient number of suitable waste containers should be available to accommodate the refuse that is generated. They should be of a type and design that will make their content inaccessible to insects and rodents and that meet fire safety requirements.[49] Non-metal waste baskets should be fire-resistant and listed by Underwriters Laboratories or other recognized organizations.

Non-hazardous waste should be collected and disposed of daily or at a frequency that has been specified in the unit's policy.[50] There should be provisions for the reclaiming of recyclable materials.

Written policies and procedures should be available for handling, storing and disposing of hazardous chemical, infectious and radioactive waste. These should be reviewed and approved by the regulatory authority.

11. Housing

Housing for the incarcerated should be in structures that are sound, safe, provide protection against the elements and accommodate basic human physiological and psychological needs. Adequate space should be available for sleeping, living and recreation.[51] Each inmate should be furnished with a single bed, clean mattress, pillow, pillow case, sheets, blankets, and a locker or cabinet for the safe and orderly storage of personal property. There should be sufficient and convenient electrical outlets that accommodate inmate-owned appliances without extension cords.

Inmates should be provided unimpeded access to drinking water, toilets and handwashing facilities. Showers, sinks, and toilets should be in sufficient numbers to meet the needs of the inmates.[52]

Inmates should be afforded as much privacy as is possible without compromising security and without sensory deprivation. Privacy partitions should be of a type and design that conform with fire safety and sanitation requirements. Floor coverings should not impede easy and effective housekeeping nor should they present a slip or trip hazard.

Ventilation should be adequate for controlling air pollutants, odors and excessive heat.[53] During the summer months, the interior temperature should not exceed the outside temperature by more than 10° F. If interior temperatures rise above 90° F for eight or more consecutive hours, a heat stress program should be initiated. This program should provide for the availability of ice, fluid replacement, fans and showers. Medical staff should make frequent tours of the housing areas to assess inmates' health and the effectiveness of the heat stress program.

The heating system should be adequate to maintain ambient air temperatures within the winter comfort zone, ideally at 68° F at 18 inches above the floor.[54] There should be provisions in the emergency plan in the event the heating system fails and that results in air temperatures below 65° for

more than 12 hours.

All areas of occupancy in the housing units should be provided with adequate natural and artificial illumination.[55] Windows that are not less than 10 percent of the floor area in size are recommended. Artificial illumination should be sufficient for grooming, reading, safety and security. Light fixtures should not be permitted to be altered or shaded by inmates.

Interior finishes should be smooth, easily cleanable and conform to the fire and safety requirements. They should be light colored to accommodate housekeeping and to enhance illumination. They should be of a material that will enable noise control to be maintained within acceptable limits.

12. Accident Prevention/Safety

Living, working and other areas of occupancy must be safe. Engineering and administrative controls should be in place to prevent conditions that cause fires, electric shock, cuts, scalds, burns, trips, slips and falls. Each facility should have policies and procedures to ensure conformance with applicable National Fire Prevention Association standards, local electrical and fire safety codes, and occupational safety and health standards.[56] There should be a safety training program for all employees and inmate workers. Vocational training for inmates should include a shop safety curriculum.

Internal and external safety inspections should be conducted as required by NCCHC, APHA and ACA standards.[57] The institutional environmental health technician should maintain a log of all injuries and illnesses that may be related to the environment. This information should be tabulated and submitted to the central office program manager for evaluation and, if necessary, for revising engineering and administrative controls.

13. Disaster Planning

Each correctional institution should have a written and periodically rehearsed emergency action plan for natural and man-caused disasters such as floods, tornados, fires, explosions, utility outages, accidental releases of hazardous chemicals etc.[58] It should be developed and updated annually in cooperation with the fire department, ambulance service, hospital and other emergency response units. The plan should establish a chain of command to minimize confusion and identify the individuals that are to respond to the emergency. It should include methods of reporting the emergency and procedures for all response activities, including evacuation, control/security, and the employment of internal and external resources and support systems. The responsible individuals should be trained for each type of disaster so that they are familiar with what actions are required. Training is necessary at least annually, whenever the plan is updated or revised, when rehearsals indicate a need for improvement and for all new employees.[59]

The facility's written emergency plan should specify the role of the health unit. If it does not, there should be a specific plan developed for the health unit that can be generic for all emergencies. It should specify the security and medical chain of command, and should address the procedures for setting up a medical base of operations outside the health unit. The plan also should include procedures for triage, kinds of equipment to be used for each situation, transport and security of medications, and list coordinating support services to be used such as ambulances, hospitals etc. The health services disaster plan should be drilled at least annually, although more frequent drills are desirable. Each drill needs to be critiqued so that any problems identified in the procedures can be corrected and positive actions reinforced.

C. Communicable Disease And Infection Control

In the previous section, many of the environmental health issues that confront institutions were discussed. Communicable diseases also can result in short or long term problems that greatly stress an institution. Most communicable disease outbreaks can be prevented and/or contained to a great degree. In order to deal more effectively with communicable diseases in the correctional setting, it is important to understand the types of communicable diseases that are most likely to present themselves and the measures that can be taken in response, either in a preventive or a reactive fashion. In this section, information necessary for institutions to develop effective infection control and communicable disease programs is presented.

1. Most Prevalent Infectious Diseases in Inmate Populations

Sexually-transmitted diseases frequently are

discovered during intake physical examinations. Syphilis, gonorrhea and chlamydia are found in both adult and juvenile inmate populations. Sexually-transmitted diseases are linked increasingly to illegal drug use. Prostitution for drugs is a common occurrence. The best sex education lessons may be lost when a person is in a drug-induced mental state. Multiple sexual partners without the protection of condoms can result in repeated infections with the potential for long-term problems including those associated with late latent syphilis, neurosyphilis, syphilis in pregnancy, congenital syphilis and pelvic inflammatory diseases that can lead to sterility and ectopic tubal pregnancies.[60]

A study by Raba and Obis (1983) at the Cook County Jail in Chicago demonstrates data rather typical of large urban jails and inclusive of the majority of persons who are committed to prison systems from urbanized areas. All detainees entering the jail were tested by urethral culture before urination. Over five percent had positive cultures for gonorrhea, suggesting annual incidence rates at least 11.2 times greater than the U.S. population rate, 4.85 times greater than the Chicago rate and 3.4 times greater than the U.S. black rate. These men were almost all symptom-free, thus exploding the myth that male carriers of gonorrhea always have symptoms. Additionally, three percent of the men admitted to the jail were found to have true positive tests for syphilis of undetermined stage.[61]

While sexually-transmitted diseases alone impact on a person's health, they also may predispose a person to bloodborne viremia. Open sores created by sexually transmitted diseases can be portals of entry for the almost always lethal human immunodeficiency virus (HIV). HIV infection and hepatitis B (HBV) are classified as sexually-transmitted and bloodborne diseases.[62] Both are found in ever-increasing numbers in the inmate population.

Each year, an estimated 300,000 persons (primarily young adults) are infected with HBV. One-quarter become ill with jaundice, more than 10,000 patients require hospitalization and an average of 250 die of fulminant disease. The United States currently contains an estimated pool of 750,000 to 1,000,000 infectious carriers. Approximately 25 percent of carriers develop chronic active hepatitis, which often progresses to cirrhosis. Furthermore, HBV carriers have a risk of developing primary liver cancer that is 12 to 300 times higher than that of other persons. An estimated 4,000 persons die each year from hepatitis B-related cirrhosis, and more than 800 die from hepatitis B-related liver cancer.[63]

Studies have indicated a higher prevalence of HBV in prison populations than is found in the community population. Reports of seroepidemiology studies of hepatitis B in Tennessee prisoners noted a 2.3 to 4.1 percent prevalence of HBsAg among men on admission to prison, a finding suggesting a high level of HBV transmission among this population before their entry to prison. It is not known whether this high prevalence of HBsAg among prisoners at admission is associated with high levels of HBV transmission within prison. A study underway in 1991 in the Illinois DOC should help to answer this question.

A prevalence serosurvey performed on an 11.7 percent sample of the 6,503 adult male inmates in Tennessee prisons showed 0.9 percent of the prisoners possessed hepatitis B surface antigens, and 29.5 percent had one or more serum markers for the hepatitis B virus (HBV).[64]

HIV infection continues to be an extremely serious public health problem in the United States and around the world. Through May 1990, the cumulative total of persons meeting the Centers for Disease Control definition for AIDS in the United States was 136,204.[65] Sixty percent of these persons identified exposure to the infection from male homosexual/bisexual contact, 21 percent reported intravenous drug use and 7 percent identified male homosexual/bisexual contact and intravenous drug use. Since the virus was first identified and methods of transmission recognized, massive education programs have brought about behavior changes in the male homosexual community resulting in fewer infections. Unfortunately, the same cannot be said for intravenous drug users. Their numbers are ever-increasing for both men and women. Heterosexual HIV infection is increasing also. Frequently, this is a result of the female being infected by her male intravenous drug-using partner. She then can infect her babies during pregnancy or the birth process. Heterosexuals also must be educated to practice "safe sex" to slow the spread of the disease.

The vast majority of inmate AIDS cases in the United States and Canada continue to be among men. Over 60 percent (1,933) of the U.S. cumulative total inmate cases were identified by racial and ethnic group. Of these, 521 (27%) were white, 880 (46%) were black and 532 (27%) were Hispanic.

Prison and jail AIDS cases continue to be overwhelmingly attributed to IV drug use and homosexuality, as do all AIDS cases. Analysis of AIDS cases among New York state prisoners through July 31, 1988 revealed that 94 percent had histories of IV drug use.[66]

AIDS education is the most critical component in the management of HIV infection in correctional settings. All staff must be schooled in the management of persons with HIV infection. A thorough understanding of the modes of transmission of this infection will allay fears in the unknowing and foster a therapeutic climate for both staff and inmates.

Health care staff must be trained to identify those inmates who have experienced high-risk behavior and to recognize those persons who possibly are infected. Health care staff must be knowledgeable about the etiology, diagnosis and treatment of all phases of HIV infection. They also must be familiar with the CDC's surveillance definition of AIDS.[67]

Inmates must be provided with information about HIV infection that is easily understood. Owing to the large number of Hispanic inmates in some systems, educational materials should be available in Spanish also. Inmates need an understanding of the modes of transmission of this disease and how they may prevent themselves from becoming infected. The risks of tattooing, sharing needles and razors, and anal intercourse must be emphasized. Recognition of early symptoms of the disease such as white patches in the mouth, weight loss, fatigue, swollen glands and diarrhea is important. This knowledge allows the inmates to present themselves to health care providers for supportive treatment.

Tuberculosis (TB) is another contagious disease that is of concern in correctional facilities. Tuberculosis had been on the decline since the early 1950s. In 1985, this trend reversed, and showed a correlation with the increasing number of persons with HIV infection and AIDS.

TB remains a problem in correctional institutions where the environment is often conducive to airborne transmission among inmates, staff and visitors. In a survey of TB cases reported during 1984 and 1985 by 29 state health departments, the incidence of TB among inmates of correctional institutions was more than three times higher than that for nonincarcerated adults aged 15 to 64 years. Since 1985, 11 known TB outbreaks have been recognized in prisons in eight states.[68] In addition, in some large correctional systems, the incidence of TB among state inmates was 109.9 per 100,000-- a rate 11 times that of the general population in New Jersey that year.[69] In a survey of California Department of Corrections facilities, the TB incidence among inmates during 1987 was 80.3 per 100,000 -- a rate nearly six times that of California's community population for that year.[70] Raba and Orbis' work at the Cook County Jail (1983) reported a 22 percent rate of positive TB skin tests, up from a reported rate of 15 percent in 1977.

HIV infection in persons with latent tuberculosis infection appears to create a high risk for development of TB. One review of AIDS cases among inmates in selected New York correctional facilities found TB in 22 (6.9%) of 319 persons with AIDS.[71]

An effective screening program for tuberculosis must be implemented as part of the reception process. Since this disease is spread primarily as a result of inhaling airborne droplets from an infected person who has coughed, this screening should be completed before inmates are transported to their permanent institutions. The intradermai Mantoux tuberculin skin test should be administered upon intake for inmates and at the time of employment for staff, and annually thereafter for both groups. TB skin tests should be interpreted in light of HIV or other complicating diseases by current guidelines as developed and published by the CDC.[72]

All inmates and staff with positive tuberculin reactions who have not previously completed an adequate course of therapy should be considered for preventive therapy unless there are medical contraindications. Treatment guidelines are fully described in a CDC publication.[73]

2. Need for Immunizations for Inmate Populations

The best way to reduce vaccine preventable disease is to have a highly immune population. Universal immunization is a critical part of good health care and should be carried out in all physician offices and public health clinics. School entry laws requiring up-to-date immunizations were passed in the early 1980s, but owing to their age, most inmates have not been affected by the recent school entry laws. Also, many are minorities from the inner cities who have not had the advantages of early infant and childhood preventive health care.

Upon intake to a correctional setting, each inmate should be questioned regarding his/her disease and immunization history. If information is not known or if the inmate is a poor historian, appropriate vaccine should be provided. Persons living in a closed environment are more susceptible to disease. Also, a person who is HIV-positive is especially vulnerable to all infections.

3. Basic Immunizations Required

All adults should receive a primary series of tetanus and diphtheria toxoids, then receive a booster every 10 years. Persons more than 65 years old and all adults with medical conditions that place them at risk for pneumococcal disease or serious complications of influenza should receive one dose of pneumococcal polysaccharide vaccine and annual injections of influenza vaccine. In addition, immunization programs for adults should provide MMR (measles, mumps and rubella) vaccine whenever possible to anyone believed susceptible to these diseases. Use of MMR vaccine ensures that the recipient has been immunized against three different diseases and causes no harm if s/he already is immune to one or more of its components.[74]

4. Aspects of Infection Control

Basic hygiene is important for all staff and inmates. Soap, water and towels must be readily available. Hand washing is the single most important means of preventing the spread of infection. Clean clothing and linens should be provided on a regular basis. Every inmate should have his/her own toothbrush, toothpaste, comb and razor. These items should not be shared with anyone. There should be a routine of housekeeping chores that allows the inmate proper management of personal items and disposal of waste.

a. Universal Precautions

The increasing prevalence of hepatitis B and HIV infections increases the risk that health care workers will be exposed to blood from patients infected with these diseases. This section emphasizes the need for health care workers to consider all patients as potentially infected with HIV or other bloodborne pathogens and to adhere rigorously to infection control precautions for minimizing the risk of exposure to blood and body fluids of all patients.[75] The premise that all bodily fluids are considered potentially hazardous is the cornerstone of universal precaution infection control procedures.

Universal precautions are intended to prevent parenteral, mucous membrane and non-intact skin exposures of health care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health care workers who have exposure to blood. Universal precautions apply to blood and to other body fluids containing visible blood. Occupational transmission of HIV and HBV to health care workers by blood has been documented, although not in a correctional setting.[76] Blood is the single most important source of HIV, HBV and other bloodborne pathogens in the occupational setting. Infection control efforts for HIV, HBV and other bloodborne pathogens must focus on preventing exposure to blood as well as on delivery of HBV immunization.[77] The use of gowns, goggles and other equipment is indicated only when there is a likelihood of blood contamination.

b. Modes and Risks of Virus Transmission in the Work Place

Although the potential for HBV transmission in the work place is greater than for HIV, the modes of transmission for these two viruses are similar. Both have been transmitted in occupational settings only by percutaneous inoculation, or by contact of blood or blood-contaminated body fluids with an open wound, non-intact skin (e.g., chapped, abraded, weeping or inflamed), or mucous membrane. Blood is the single most likely source of contracting HIV or HBV in the work place. Protective measures against HIV and HBV for workers should focus primarily on preventing these types of exposures to blood as well as on delivering HBV vaccinations.[78] Even though nationally there are hundreds of daily occurrences of inmates spitting, biting and throwing bodily waste on officers, there is no documented instance of HIV transmitted to an officer as a result of such behavior.

A section of CDC's guidelines for preventing transmission of human immunodeficiency virus and hepatitis B virus to health care and public safety workers is devoted to risks encountered by law enforcement and correctional facility officers during the conduct of their duty.[79] Correctional officers often are required to search prisoners and their cells

for hypodermic needles and weapons. In accomplishing this task, they must be ever vigilant to prevent puncture wounds from possibly contaminated needles or weapons. Great caution should be used in searching clothing. The inmate should be asked to empty and turn pockets inside out for better visualization. Flashlights should be used when searching dark or hidden areas. The officer should never reach into a darkened area without first ascertaining by a visual inspection that the area is safe. Caution should be foremost in the officer's mind during the process of any search.

The use of latex gloves is necessary only when there is possible exposure to blood. Latex gloves will not prevent needle or puncture sticks. Only careful vigilance prevents contamination from puncture sticks.

Correctional officers may be exposed to blood during assaults, fights, stabbing, nosebleeds, sports injuries or any number of other ways. If a situation occurs where there is anticipated exposure to a person's blood, protective clothing such as latex gloves, disposable gowns, masks and goggles should be worn and after use, disposed of as infectious waste. If there is accidental exposure of blood to exposed skin, the skin should be washed immediately with soap and water. Soiled clothing should be removed and properly laundered. Blood spills should be removed by someone wearing latex gloves. The contaminated area should be cleaned with soap and water followed by a 1:10 solution of household bleach and water.

c. Isolation Procedures

Upon suspicion or diagnosis of a communicable disease, the inmate must be examined promptly by a physician. The inmate should be kept in a room separate from other inmates until a determination is made as to the necessity for and type of isolation required. It is always safer to over-isolate than to under-isolate when the diagnosis is uncertain. This is especially true in a closed environment. Also, when a need for isolation has been identified, all personnel must carefully comply with any posted precautions.

A private infirmary room with handwashing facilities and bathing and toilet facilities is required most often. An infirmary room with special ventilation (vented to the exterior) is necessary for a respiratory disease such as tuberculosis. Use of masks, gowns, gloves, bagging of used articles, disposal of infectious waste and other environmental issues are covered completely in other literature.[80]

5. **Determining Appropriate Isolation Precautions for Diagnosed Infectious Diseases**

The Centers for Disease Control publishes a series entitled *Guidelines for the Prevention and Control of Nosocomial Infections (1983)* that is designed for use by personnel responsible for infection surveillance and control. These guidelines are printed in loose-leaf form to allow for periodic update and revision. Among the guidelines available is one for isolation precautions in hospitals. It is an extremely useful reference as it provides specific directions for isolation precautions summarized in tables by category (e.g., contact, enteric, respiratory) and by disease. The latter table (Table B. Disease-specific Isolation Precautions) has columns that list the disease; whether a private room is needed; whether masks, gowns and gloves are needed; which materials may be infective; how long precautions are to be applied; and specific helpful comments.

This document should be made available to all health care units. All staff should be notified of its contents and location. It is a ready reference to determine the appropriateness of isolation and other infection control precautions, which will provide a safer environment for inmates and staff.

D. Health Education

Many inmates have enjoyed few of the socioeconomic benefits of our society. From the time of conception, their health may have been adversely affected by inadequate or absent prenatal care of the mother, by maternal substance abuse or by trauma. During childhood, there may have been inadequate preventive health care, inadequate nutrition, environmental stressors, trauma, substance abuse, and/or inadequate or absent medical care and the knowledge to maintain good health. As a result, many inmates come into correctional facilities with chronic illnesses and their complications that could have been prevented. Their lifestyles have created situations where their physiological age frequently exceeds their chronological age. To identify inmates' health problems, appropriately treat all of their conditions and provide previously neglected health education becomes a mammoth challenge for

correctional health staff.

A screening of each individual's health during the intake process is a critical beginning to the management of these individuals. A detailed history should be taken by a health professional who can communicate effectively with the inmate. Care must be taken to address health care issues that are seen frequently in this population (e.g., trauma, substance abuse, tuberculosis, venereal diseases). A thorough physical examination by a physician or physician assistant should follow. Mental and dental health should be evaluated and care provided as needed (see Chapter VII).

Careful assessment and treatment at the time of intake protect the health of all inmates as well as staff.[81] This is extremely critical in the closed environment of a correctional facility. Also, the information obtained from these assessments will aid in the development of health promotion activities based on need.

1. Need for Health Education for Inmates

Assisting inmates to take responsibility for their own health through lifestyle changes is a major challenge for health care staff. Clearly, life can be extended and the quality of life improved by practicing good health habits. With ever-increasing inmate populations, there is a financial aspect to health promotion that cannot be ignored. Diminishing resources dictate that administrators spend wisely. It may prove more economical to invest resources in health education and preventive health programs than to deal with the escalating costs of treating many illnesses and their complications.

Providing health education to inmates not only helps them to take better care of themselves, but also may contribute to their utilizing health services on a more rational basis. The more they understand about their bodies and their illnesses, the less likely they are to misuse the services available.

2. Role of the Health Services Central Office Personnel

The statewide health services director should assign a health care professional to develop the health education program, preferably a health educator. This person should be knowledgeable regarding the special needs of the inmate population and be able to communicate effectively to institutional personnel methods to assist in the health education process. The statewide health education coordinator generally is responsible for assembling resources such as informational articles, bibliographies, audiovisual materials and pamphlets. S/he also often provides additional programs by compiling or developing curricula and lesson plans for group health education.

Education materials should be developed at a level that can be readily communicated to and understood by inmates. This usually requires the assistance of a professional educator. Alternatively, the health education coordinator can check with national clearinghouses and organizations to determine what resources designed for an inmate population are available.[82] In view of the large number of Spanish speaking persons in the prison population of several states, educational materials should be provided in Spanish as well as English whenever indicated.

3. Role of Institutional Health Personnel

Institutional health personnel can provide regularly scheduled programs of interest to the inmate population that are targeted to their special needs. AIDS education, sexually transmitted disease education, common chronic illness education and general health promotion topics can be of value to inmates and assist in promoting health and well-being.

Methods of reaching inmates are many and the cost of a health education program can be minimal. In addition to one-on-one counseling at the time of health encounters, classes led by a health professional can be very successful. Time should be allowed for appropriate interaction between the health professional and inmates. Question and answer sessions promote improved inmate understanding. Topics should be varied and presented in an interesting fashion using multiple media resources whenever possible.

Informational pamphlets are another excellent means of providing instruction. Also, if closed circuit television is available in the institutions, instructional videotapes can be aired at scheduled times throughout the day. Videotapes can be borrowed from local health departments and service agencies such as the American Red Cross, American Lung Association, American Heart Association, American Cancer Society, dairy councils and public libraries.

4. Basic Health Education Topics

The five leading causes of death in the U.S. are heart disease, cancer, stroke, accidents and chronic obstructive pulmonary disease.[83] Persons identified during the intake process as having one of the chronic diseases such as hypertension, diabetes, asthma or seizure disorders should be managed in a chronic illness clinic and their clinical status evaluated by a health care professional on a regularly scheduled basis. Health education is a critical component of these clinics.

All inmates should receive information on nutrition, weight control, exercise, stress reduction, the dangers of tobacco use, the dangers of tattooing and the avoidance of sexually-transmitted diseases. Women should be taught the importance of monthly breast self-examination and receiving Pap smears regularly, and men should know the importance of testicular self-examination.

At a minimum, there are two topics that should be addressed aggressively in every institution: tobacco use, because of the high prevalence among inmates and its deleterious effects on health status; and AIDS, because of the fear associated with it and its fatalness. In both instances, providing health education can lead to changes in behavior.

a. Tobacco Use

Tobacco use is responsible for more than one of every six deaths in the United States and is the single most preventable cause of death and disease in our society. Tobacco use is a major risk factor for diseases of the heart and blood vessels; chronic bronchitis and emphysema; cancers of the lungs, larynx, pharynx, oral cavity, esophagus, pancreas and bladder; and other problems such as respiratory infections and stomach ulcers. Passive or involuntary smoking also causes disease, including lung cancer, in healthy non-smokers.

An estimated 390,000 deaths are directly attributable to cigarette smoking each year in the United States. Cigarette smoking is responsible for 40 percent of all coronary heart disease deaths, 83 percent of lung cancer deaths and 35 percent of all cancer deaths in the United States. Among men, lung cancer death rates began to climb sharply in the 1930s approximately 20 to 30 years after men began smoking in large numbers. Among women, a nearly identical increase in lung cancer deaths began in 1960 approximately 20 to 30 years after the post-World War II surge in women's smoking. As a result of the declining prevalence of smoking among men, lung cancer death rates for men have begun to level off. Among women, lung cancer death rates continue to increase and, in 1986, almost equalled breast cancer as the leading cause of cancer death for women.

Since 1965, we have seen a dramatic reduction in tobacco use in this country. Total and per capita cigarette consumption have declined steadily. The prevalence of smoking among adults has decreased from 40 percent in 1965 to 29 percent in 1987. Unfortunately, nearly one-third of all adults in the United States continue to smoke. The decline in smoking has been substantially slower among women than among men. The prevalence of smoking also remains disproportionately high among blacks, blue-collar workers and people with fewer years of education[84] -- essentially the same population seen in U.S. prisons.

Owing to the magnitude of health problems created by cigarette smoking, education of the inmate population regarding its hazards should be provided continually. Inmates and correctional staff traditionally are known to be frequent users of tobacco products. In a survey conducted May 1, 1990 in a women's prison in Illinois, 81 percent of those completing the survey were cigarette smokers with 73 percent reporting smoking at least one package of cigarettes per day. Prior surveys of male prisoners have shown smoking prevalence rates of about 85 percent, which is almost three times that of the noninstitutional population.[85]

What can be done to educate inmates on the hazards of smoking and provide assistance to those who desire to quit? The American Lung Association and the American Cancer Society have an extensive list of informational materials available. Some are without charge and others are available at a minimal cost.

The Supply Service Catalog provided by the American Lung Association (ALA) of Illinois lists available products and their costs. The ALA has developed "In Control" -- a stop smoking program on videocassette. The person watches one 9-minute video segment each day for 13 days. Each gives motivation, encouragement and specific techniques on how to become a permanent ex-smoker.

Identifying inmates who have the desire to quit and meeting with them regularly in a group can assist them in attaining their goal to quit smoking. Education must be ongoing. Inmates should be

allowed to choose to live in smoke-free environments whenever possible. Lessening the number of smokers in correctional facilities will go far toward improving the health of all staff and inmates.

b. AIDS Education

The number of AIDS cases in the United States reported to the Centers for Disease Control (CDC) continues to increase. Over 35,000 new cases were reported in the year ended October 31, 1989, bringing the cumulative total of adult/adolescent AIDS cases reported to CDC to 110,333. Of these, 59 percent had died by the end of October 1989.[86]

Beginning in late 1985, the National Institute of Justice has sponsored annual surveys of the prevalence and management of AIDS in the nation's federal and state prison systems as well as some of the larger jails. A 1990 update indicated that by October-November 1989, a cumulative total of 3661 confirmed AIDS cases was reported by the 50 state correctional systems and the federal prison system. The 1989 data revealed that for the first time, "...the percent increase in cumulative total correctional cases in the United States (72%) exceeded the increase in cases in the U.S. population at large (50%)."[87]

The annual incidence of AIDS in the total U.S. population was 14.65 cases per 100,000 in 1989 versus an aggregate incidence for the state and federal correctional systems of 202 cases per 100,000 in 1989. The higher incidence in corrections is attributed to the overrepresentation of individuals with histories of high risk behavior, especially intravenous drug use.[88]

While the distribution of AIDS cases in state and federal correctional facilities was far from even -- 14 percent of the systems contributed 84 percent of the cases in 1989 -- there were only five systems that had not had a single AIDS case by 1989, compared with 26 systems which reported no AIDS cases only five years earlier.[89] Clearly, all correctional systems will have to confront the problems of AIDS sooner or later.

In the absence of an AIDS vaccine, educating individuals about how the disease is contracted and what they can do to reduce their chances of becoming infected remains the best hope for reducing the incidence of AIDS and HIV infection. NCCHC recommends that AIDS education be offered to all inmates as well as to all correctional and medical staff.[90] Educational sessions using live instructors are preferred, since this strategy allows inmates to voice their own fears and concerns and have their questions answered on-the-spot. Live sessions can be supplemented with written materials and audio-visual presentations tailored to the correctional population. Such materials are readily available.[91]

Some systems are experimenting with peer education (i.e., inmate trainers) to get the message across to prisoners about the consequences of their high risk-taking behaviors. Moini and Hammett report that in 1989, seven of the state/federal correctional systems were using inmates for at least some of their live AIDS education programs.[92]

The Illinois Department of Corrections is experimenting with another type of peer education. In September 1990, an AIDS pre-release education program was initiated by the Illinois DOC in conjunction with the Illinois Department of Public Health. An ex-offender was hired to work with an AIDS educator in the development of the program. All women and girls in the IDOC are targeted to participate in a three-hour session one to two months prior to release. Topics covered in the session include AIDS education with an emphasis on risk reduction and prevention, maintenance of reproductive health, and avoidance of all sexually transmitted diseases. Lists of helping agencies in the community are provided to assist the individuals in meeting their health needs. The ex-offender discusses life stressor management upon release from incarceration. By all accounts, this peer education component has been well-received by the inmate population.[93]

The content of AIDS education programs for inmates remains somewhat controversial since the risk-taking behaviors that should be discussed (namely, IV drug use and unsafe sexual practices) are both activities prohibited by correctional systems. Nonetheless, it is imperative that inmates receive information about how to protect themselves from this disease. The full extent of HIV infection in corrections is unknown, but in states where blinded epidemiological studies have been conducted, the seroprevalence results for male inmates ranged from 0.6 percent to as much as 17 percent.[94]

While information about unsafe sexual practices is an important component of AIDS education programs for inmates, information about cleaning drug injection equipment is even more crucial, since IV drug use is the activity that puts more inmates at risk of becoming HIV infected. Unlike condoms, no

one is suggesting that inmates be issued clean drug injection equipment while incarcerated. Still, it seems extremely short-sighted not to provide inmates with information they can use to protect themselves from HIV infection when they are released. In 1989, fewer than half of the prison systems reporting were including information on cleaning drug "works" in their inmate educational programs.[95]

c. Other Topics

Health education for inmates in most systems is a very low priority. In NCCHC accreditation surveys, staff consistently find that the standard on health promotion and disease prevention is either unmet or only minimally met by providing health education materials in the medical unit. The effectiveness of health education as a preventive step is always difficult to measure since the evidence is indirect and often, not immediately demonstrated. It is sometimes difficult to convince administrators that they should allocate scarce resources to a program whose results are not easily seen, but implementing health education programs can be an effective cost-saving strategy in the long run. Almost no one would contest the fact that the Surgeon General's educational campaign against smoking has resulted in dramatic decreases over time in the percentage of Americans who smoke. Once a constitutional system of care is in place, correctional health professionals need to turn their energies toward the development of extensive health education programs for inmates.

There are a handful of correctional institutions that are experimenting with innovative inmate health education programs. For example, the Gatesville Unit of the Texas Department of Criminal Justice (TDCJ) has developed a pre-natal course with some incentives built in to encourage female inmates to participate. It is a five week program that includes pre-natal classes twice a week, exercise classes three times per week and medication compliance checks. Depending on the extent of their participation, inmates can earn extra personal hygiene items on a weekly basis and receive additional privileges on completing the course. While no formal evaluation has been conducted, the coordinator reports excellent attendance by participants.[96]

Also, TDCJ's dental director has developed an aggressive oral hygiene program for inmates. In fact, he has identified patient education as a priority second only to treating emergency/urgent conditions. Inmates admitted to TDCJ with moderate to advanced periodontitis are offered small group oral self-care counseling as part of the intake process. Individual counseling in plaque control is available at the inmate's unit of assignment, providing s/he demonstrates an acceptable level of compliance with oral hygiene measures. The inmate's commitment to maintaining an acceptable oral hygiene level helps determine his/her eligibility for other non-emergency dental services.[97]

Another interesting approach to health education was tried at the Lieber Correctional Institution in South Carolina in 1988. A six week program was developed that consisted of three components: daily exercise, weekly classes on health and a smoking cessation group. Post-program evaluation showed that 66 percent of the participants lost weight during the six week program. More important, there was a 61 percent reduction in sick call visits by group participants for the six weeks during and six weeks post program, compared to their number of visits for the three months pre-program.[98]

E. Conclusions

In many correctional systems, just meeting inmates' day-to-day health care needs can seem an overwhelming task. As a consequence, health promotion and disease prevention activities are given a low priority, when in fact, the opposite should occur. Failure to address adequately environmental health issues, to control the spread of infection and to provide health education for inmates leads to increases in the utilization of already overburdened health services. Strong emphasis should be placed on preventive health measures. One of the most effective ways to reduce disease and control costs is to ensure that inmates live in healthful surroundings and are provided with information on improving their own health status.

Correctional health administrators and clinicians are urged to explore liaisons with their county and state public health departments. These agencies have the necessary expertise and resources to assist in the development and implementation of preventive health programs including immunizations, infectious disease control, environmental sanitation measures and health education efforts.

ENDNOTES

1. Registration through the National Environmental Health Association, 720 S. Colorado Boulevard, Suite 970, Denver, Colorado 80222 is recommended in states without a sanitarian registration act.
2. Certification through the Board of Certified Safety Professionals, 208 Burwash, Savoy, IL 61874.
3. See ACA (1990); NCCHC (1987); and Dubler (1986).
4. Suggested are at least 30 college credits in physical and biological sciences plus CDC's homestudy course 3010 G-Community Hygiene (Centers for Disease Control, Center for Professional Development and Training, Homestudy Services Branch, Atlanta, GA 30333) plus attendance at course 501, a Guide to Voluntary Compliance in Safety Training Institute, 1555 Times Drive, Des Plaines, IL 60018. Also, certification in "Applied Food Service Sanitation" through the Education Foundation on the National Restaurant Association, 250 Wacker Drive, Suite 1400, Chicago, IL 60606-5834.
5. See NCCHC Standard P-14; ACA Standard 3-4302 through 3-4306; and APHA Environmental Standard B-4, pp. 68-69.
6. See NCCHC Standards P-14 and P-22; and ACA Standard 3-4303.
7. See NCCHC Standard P-13; ACA Standard 3-4302, 3-4304 and 3-4310; and APHA Environmental Standard B-4, p. 69.
8. See ACA Standard 3-4303.
9. See NCCHC Standard P-22.
10. Certification course equivalent to Applied Food Service Sanitation, by The Educational Foundation of the National Restaurant Association.
11. See ACA Standard 3-4313; and NCCHC Standard P-45.
12. See APHA Environmental Standard B-10, pp. 73-74.
13. *Ibid.*
14. *Ibid.*
15. See ACA Standards 3-4144 and 3-4154; and APHA Environmental Standard B-1 p. 66.
16. NCCHC Standard P-48; and APHA Environmental Standard B-1, p. 66.
17. See APHA Environmental Standard B-12, p. 75.
18. See ACA Standard 3-4311; and APHA Environmental Standard B-12, p. 75.
19. See APHA Environmental Standard B-18, p. 72.
20. See ACA Standards 3-4132--4135; OSHA Standard 1910.41; APHA Environmental Standard C-1, pp. 75-76, C-2, pp. 76-77, and E-3, p. 78.
21. See ACA Standard 3-4137.
22. See ACA Standards 3-4134 and 3-4323; and APHA Environmental Standard B-8, p. 72.
23. See APHA Environmental Standard B-8, p. 72.
24. See APHA Environmental Standard B-11, p. 74; and ACA Standard 3-4312.
25. See ACA Standard 3-4141.
26. See ACA Standard 3-4138.
27. See APHA Environmental Standard B-7, pp. 71 and 72.
28. See ACA Standard 3-4143.
29. See Freeman (1977: 1075).
30. See OSHA Standards 29 CFR 1910.95 and 20 CFR 1926.52.
31. See ACA Standard 3-4314.
32. See ACA Standard 3-4310; APHA Environmental Standards B-5, pp. 69-70 and F-2, pp. 88-89; and NCCHC Standard P-13.
33. See ACA Standard 3-4155; and APHA Environmental Standard B-5, pp. 69-70.
34. See ACA Standard 3-4319.
35. See ACA Standard 3-4321; APHA Environmental Standard E-2, p. 85; and NCCHC Standard P-49.
36. See ACA Standard 3-4319.
37. See APHA Environmental Standard B-7, pp. 70-71.
38. See ACA Standard 3-4325.
39. See NCCHC Standard P-40; and APHA Environmental Standard C-3, p. 77.
40. See APHA Environmental Standard C-3, p. 77.
41. See ACA Standard 3-4332; and NCCHC Standard P-28.
42. For example, through NCCHC accreditation.
43. See APHA Environmental Standard C-4, pp. 77-78; NCCHC Standards P-40 and P-45; and ACA Standard 3-4341.
44. See APHA Environmental Standard B-8, p. 72.
45. See APHA Environmental Standard C-4, pp. 77-78; and NCCHC Standard P-29.
46. See ACA Standard 3-4137; and NCCHC Standard P-56.
47. See NCCHC Standard P-55.
48. See ACA Standard 3-4206.
49. See ACA Standard 3-4202; and APHA Environmental Standard B-9, p. 73.
50. APHA Environmental Standard B-9, p. 73.

51. See ACA Standards 3-4128, 3-4130, 3-4135-4137, 3-4147 and 3-4148; and APHA Environmental Standard E-4, pp. 86-87.
52. See ACA Standards 3-4132 through 3-4133.
53. See APHA Environmental Standard B-1, pp. 65-66 and B-2, pp. 66-67; and ACA Standards 3-4144 thru 4146.
54. See ACA Standard 3-4146.
55. See ACA Standards 3-4138 through 3-4142; and APHA Environmental Standard B-7, p. 71-72.
56. See ACA Standards 3-4120, 3-4121, 3-4199 through 3-4203 and 3-4401; and APHA Environmental Standards D-1, pp. 79-80, D-3, pp. 80-82, D-4, pp. 82-83, and D-6, pp. 83-87.
57. See NCCHC Standard P-13; ACA Standard 3-4199, 3-4200, 3-4401; and APHA Environmental Standard F-2, pp. 88-89 and F-3, p. 89.
58. See ACA Standard 3-4209 through 3-4212; APHA Environmental Standard D-2, p. 80; and NCCHC Standards P-12 and P-43.
59. See NCCHC Standard P-12; and ACA Standard 3-4208.
60. See Sexually Transmitted Diseases Treatment Guidelines, CDC (1989d).
61. Also see King (1987).
62. Blood to blood transmission has occurred primarily through sharing of needles and "works" by intravenous drug users and, to a lesser extent, transfusions of infected blood and blood products to hemophiliacs and others.
63. See CDC (1990a).
64. See Decter *et al.* (1984).
65. See U.S. Department of Health and Human Services, 6/90.
66. See Hammett (1989:11).
67. It can be found in its entirety in the MMWR supplement, 1987.
68. CDC unpublished data.
69. New Jersey State Department of Health, unpublished data.
70. CDC (1989c).
71. *Ibid.*
72. *Ibid.*
73. CDC (1986).
74. CDC (1989b).
75. See CDC (1987).
76. See CDC (1989a).
77. See CDC (1988).
78. See CDC (1989a).
79. *Ibid.*
80. See CDC (1983a) and (1983b).
81. See Chapter VII for more information on the health intake process.
82. A number of national health organizations such as the American Lung Association, American Diabetes Association, Epilepsy Foundation of America etc. have patient education materials that can be useful. Additionally, there are two national clearinghouses that compile materials specific to corrections:

National Criminal Justice Reference Service
Box 6000
Rockville, MD 20850
800-851-3420

National Institute of Corrections Information Center
1790 30th Street, Suite 130
Boulder, CO 80301
303-939-8877
83. See CDC (1990b).
84. U.S. Department of Health and Human Services, 1989.
85. See Romero and Connell (1988) and the studies cited therein. Also see Skolnick (1990).
86. See Moini and Hammett (1990:7).
87. *Ibid*, p. 10.
88. *Ibid*, p. 12.
89. *Ibid*, p. 13.
90. NCCHC (1990).
91. Moini and Hammett (1990:39) report the following resources:

> "Extensive information on audiovisual materials is maintained by the National AIDS Information Clearinghouse (NAIC) (800) 458-5231, the National Clearinghouse for Alcohol and Drug Abuse Information (301) 468-2600, and the National Institute of Justice AIDS Clearinghouse (301) 251-5500."

92. Moini and Hammett (1990:32).
93. For more information on this program, contact Ms. Judy Coe, Illinois Department of Corrections, Springfield, IL at (217) 522-2666.
94. See Moini and Hammett (1990:18).
95. See Moini and Hammett (1990:35).
96. For additional information, contact Ms. Evelyn Winn at the Gatesville Unit in Gatesville, Texas (817) 865-8431.

97. For more information, contact T. H. Heid, DDS, Dental Director, Texas Department of Criminal Justice in Huntsville, TX (409) 294-2708.
98. Correspondence to B. Jaye Anno from Carole Bennett, RN, MN, January 31, 1989.

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CHAPTER X

PLANNING CORRECTIONAL HEALTH FACILITIES

A. Introduction

The health program in correctional institutions has assumed major importance in the last few years owing especially to court involvement and the sheer cost of health delivery. Aside from any moral considerations concerning medical care for inmates, court decisions have indicated clearly that inmates' health needs must be met. Concomitantly, issues of medical malpractice and potential legal costs make it imperative that the delivery of health services be professional and meet accepted standards of practice. At the same time, cost containment in community health care delivery has become an important national concern. It is not uncommon today to find similar scrutiny by legislative appropriations committees and others concerned with reducing the costs of health care to prisoners.

Health care issues in corrections have been addressed in other chapters of this manual and need not be discussed here; however, the efficiency and effectiveness of the health program are dependent, in part, on the physical environment in which it functions. Planning for the health unit, therefore, is a critical activity.

Medical needs have high visibility among the inmate population and can be a source of negative attitudes that permeate the inmate body and contribute to inmate unrest. Poor treatment in the form of untimely response, perceptions of uncaring attitudes of health staff or frustration with unmet needs can result in inmate control problems for security staff. The health program also has an influence on custody staff training. In many systems, pre-service and in-service training programs for correctional staff now include instructions on infectious and chronic diseases, mental illness, addiction, suicide prevention, and certification in cardiopulmonary resuscitation and first aid. Such training results in a security staff that is knowledgeable about the functions of the medical program and sensitive to the problems and needs of the health staff and the inmates.

The objective of this chapter is to present an approach to planning a health unit in a correctional facility. The variables that must be considered, the organization of the process that will address these variables and the nature of the report that is a prerequisite to a successful design are discussed as well.

The planning of health facilities in correctional institutions is a complex process and should not be viewed simply as another allocation of program space. The same planning techniques used in designing a facility and the same attention to detail must be used, if the health unit is to be an effective and functionally coordinated program of the facility. Whether the health unit is to undergo major renovation or is to be a new structure within an existing prison or part of the design of a new facility, it is a health system within a correctional organization and any planning must reflect a systems approach.

Planning is a process that aims to reconcile competing priorities: the needs of the system, the needs of the individual facility, the needs of the patients and the needs of the staff who will be working in the newly designed environment. Medical staff are concerned with adequate space for the various health activities and the layout of the space for efficient working conditions. Office and storage space, always scarce in health units, may be viewed as costly and non-functional by the administration, but are critical to health staff. Examining rooms that afford privacy are standard requirements for health staff, but pose problems for security. These competing concerns need to be addressed and resolved in the planning process.

In order to address these rival priorities, the planning process must incorporate the concerns of the major parties: the correctional administration, the health professionals and their patients, and the custody staff. The design of a health unit cannot be the sole responsibility of the administration or central office health staff or the facility health staff or the architect. All the major parties who have an interest and concern must be included in the process.

This chapter was developed by Nick Pappas.

Each group brings a frame of reference to the planning, none of which alone is sufficient for an effective planning effort.

The planning process is complex and the participants must be selected for their experience, knowledge and credibility: e.g., health administrator, physician, director of nursing, security administrator. The planning group must be viewed as an organization of equals. The attributes the individuals bring to the planning process are expertise and knowledge in their specialty area and the ability to address and resolve issues and problems.

The planning committee's task is to define and describe the health program including its objectives, organization and operation, and to provide information on space needs that will give direction to the designer. It must be understood at the outset that no planning process will result in a perfect design; however, planning will minimize error. The more rigorous the process, the smaller the probability of error.

The discussion below addresses the organization of the planning process. The assumption is that planning requires the undivided attention of at least one person for varying blocks of time, regardless of the size of the effort. The composition of the planning group and its reporting requirements may vary based on the nature of the project and the size of the organizational structure of the correctional system; however, the basic outline of the planning effort should not vary significantly from that indicated below.

B. Organizing The Planning Process

1. Creating the Planning Committee

Creating a planning committee is the first critical task in the planning process; it also is difficult because it runs counter to the bureaucratic culture. Staff find it hard to take an unfamiliar assignment, especially one that has high visibility and high risk and one that may not contribute to their career advancement. Managers resist the loss of a person for blocks of time to an activity over which they have no control.

Appointment to the planning committee should come from the director/commissioner, to whom the committee should report. The level of appointment and reporting responsibility indicates the level of importance of the task. If appointment by the top administrator in the system is followed by delegating oversight responsibility to a significantly lower level of administration, the planning assignment will be downgraded in importance.

Authorization of the committee and its membership should be in writing, with a clear statement that the planning schedule takes precedence over other routine assignments. A planning committee usually requires the full-time commitment of at least one person, the project director, and the part-time commitment of all other members. Support staff to perform clerical functions may be needed as well.

The planning committee should be small and have the authority to call on specific staff from any office in the system to serve as consultants. This will provide flexibility in the use of staff, making it possible to call in knowledgeable individuals for short periods of time as they are needed. The committee will need the input of a wide range of staff at various stages of the planning. It is necessary, therefore, that the requisite expertise be made available on an *ad hoc* basis rather than enlarge the membership of the committee. The committee should be allocated a budget that can be used for short-term hiring of outside experts, if the knowledge needed is not available within the system. There also may be a need for special studies that, because of time and staff constraints, cannot be done internally. The correctional system's usual contracting process should be used for this purpose.

a. Selecting Official Participants

1) Project director

The project director should have expertise as a health provider or a medical administrator. Since s/he will have the responsibility for organizing the planning and dealing with medical issues, knowledge of the health field is paramount. This position should be filled by a person in an administrative capacity. The job level of the project director indicates the importance attached to the task by the correctional and health administrations. The appointment of the project director should be made by the commissioner in consultation with the systemwide health director. The appointment should be in writing and should include:

a) Reporting responsibility: reports to the commissioner or deputy.

b) Scope of authority:
(1) schedule meetings;

(2) make assignments to planning committee members;
(3) set deadlines and issue progress reports;
(4) request the assistance of department staff as consultants;
(5) make use of outside consultants for expertise not available in the department;
(6) arrange site visit to another facility, if appropriate;
(7) initiate contract requests for special studies as needed; and
(8) conduct a post-occupancy evaluation of the health unit.

The appointment also should state the tasks of the committee, timelines for progress reports and a deadline for completion of the planning process.

2) Medical representative

A medical staff person from the facility must be included as a member of the planning committee. If the planning addresses a health unit in a new facility, the medical person should be from the staff of a facility as similar in size and scope of services as possible to the one being planned. The committee needs the input of someone who has had the day-to-day experience of working in a medical unit and who can contribute insights on the arrangement of space. It is understood that this individual may bring his/her biases to the planning; however, the group process should neutralize any extremes.

3) Custody representative

The representative from the custody staff is as important to the planning process as are medical personnel. The health unit depends on the cooperation of custody staff in coordinating activities such as scheduling inmates for appointments, supervising inmates in the health unit, transporting inmates for care and dealing with inmates' complaints. Custody staff are responsible for the institution as a whole and the health unit, to a large extent, must arrange its schedule around security counts, meals and inmate work schedules.

Correctional staff will be concerned with the location of the health unit, and control and security of drugs, syringes, needles and medical/dental instruments. If the health unit is to have an infirmary, there will be an interest in maintaining security for the patients and staff. Finally, custody staff can contribute to the design by ensuring that the layout provides ease of inmate supervision.

4) Administration

The person appointed from the division of administration brings a broad view of the system to the planning. Input may include political concerns (intra and inter departmental), knowledge of the system's long range goals, staffing plans and problems, and an understanding of the need for balancing priorities. The level of the person appointed is not as important as that individual's ability to convey the perspective of the administration and the political climate.

5) Budgeting/procurement representative

The planning process includes discussion of cost and cost containment issues that need to be addressed regarding the level of services desired, alternatives to and costs of various service options, equipment costs, staffing costs and the like. A fiscal representative can contribute expertise in financing the various components and options of the plan, and provide information on how the financial and procurement process operates and how it can be used in the planning process.

Some systems may have individuals who are skilled in both administrative and financial matters. If so, the responsibilities of 4) and 5) above could be combined in one participant.

6) Research/electronic data processing systems representative

The planning will require information about the inmate population to be served including but not limited to inmate health care profiles, sick call volume, type and frequency of diagnostic referrals and inpatient utilization data. If such information is not readily available, it will need to be generated or estimated for planning. Alternate methods may include estimates of utilization or sample surveys of utilization in certain areas such as number of sick call requests, clinic logs, pharmaceutical costs, hospital trip logs etc. Chapter XI on data management and documentation provides more detail on health care information needs and data collection strategies.

The health unit should be included in the prison's management information system. A representative from research with knowledge of computerized systems is needed on the planning committee to provide data, and to discuss database development and the use of information systems in management.

b. Using *Ad Hoc* Consultants

The delivery of health care includes a range of programs and special services, each of which has a variety of space and equipment needs. The planning group should use representatives from these programs and special services as *ad hoc* consultants in the planning process. For example, dental care requires dedicated space and equipment; mental health professionals need privacy for interviews and evaluation, and space to conduct group sessions; physical therapy requires special equipment. There are a host of other examples. Professionals representing these services should be used as needed in order to provide data to the committee on program and space requirements.

c. Liaison with Others

1) Facility planning and engineering office

The state office responsible for facility planning should be brought into the planning process as early as possible, usually at the stage when the administration has decided that new construction or renovation is needed. This office can assist the planning committee to refine its program and space requirements into performance characteristics and serve as liaison for the committee with the designer/architect. The planning committee should establish a close working relationship with this office.

2) Coordination with other planning groups

If the planning addresses a new facility, the health planning group should coordinate with the facility's overall planning organization, either through joint meetings or through the appointment of the health planning project director to the larger planning group or both. This is imperative in order to reach agreement on issues such as the location of the health unit, the provision of health services to segregation and isolation areas, specifications and location of special housing for medical watch inmates, the location of the medication window and the development of emergency plans.

Care should be taken to involve the health planning committee at an early enough stage to have effective input into larger decisions affecting the rest of the new facility under design. Too often, health care issues are an afterthought in correctional settings. Input from the medical staff is sought at the last minute, after all other decisions have been made. This approach usually results in a less than ideal solution for all concerned. Communication between the health planning committee and the facility planning organization should be interactive and iterative, so that each group builds on the expertise of the other. Sound creative solutions become possible in this kind of environment.

3) Designer/architect

It is difficult to state precisely at what point coordination with the designer/architect should occur. The planning process should begin early with the identification of needs that will serve as the basis for justifying a building/renovation program. The state's contracting requirements, which are usually out of the control of the health planning committee, generally determine when a designer/architect will be available. The planning committee should work closely with the designer as soon as s/he is selected; however, much of the work of the committee can proceed prior to the availability of the designer.

2. Defining Tasks And Responsibilities

The first task of the planning committee is to define its scope of activities. These include:

a. identifying information needs;
b. surveying medical resources;
c. examining options for health care delivery (including costs);
d. determining levels of care;
e. developing a medical unit budget;
f. developing a staffing pattern; and
g. identifying equipment needs.

The second step is to clarify the duties and responsibilities of individual members. Although each member is selected for his/her particular expertise, it must be made clear that this is a committee of equals and that anyone can make a contribution outside of his/her specialty area.

It should be noted that the planning committee is not responsible for creating a design. Its responsibility is to provide the kind of information necessary to the designer/architect so that a design can be developed. Regarding programming, one writer said:

> *Analysis studies and evaluates, while programming ORDERS the evaluation, establishing patterns by which courses of action can be taken. Programming is thus the decision making process through which a conceptual layout of spatial requirements and their relationships will be accepted, modified, adjusted, or even changed in order to produce a final composite of determinants making up the initial postulates from which any design process must derive* (Marti, 1981).

Another author addressing medical facility planning had this to say:

> *Simply stated, functional planning of hospital facilities relates to those efforts before design that determine operational concepts and specify functions (in terms of procedures, required equipment and numbers and categories of space users) that will take place in the spaces of a proposed structure, both individually and collectively. However, the scope of functional planning duties has now been extended to include the actual descriptions of facilities, in narrative or graphic form, that deal with interdepartmental and intradepart-mental relationships, traffic flows of all types, and methods for obtaining flexibility and expansibility -- all of which were once considered the province of the design architect* (Hardy and Lammers, 1986).

The two comments above clearly lay out the responsibilities of the planning committee and its relationship with the designer/architect. The end product of the committee's efforts is to produce an architectural program that will provide the basis for the design of the health unit.

3. Defining The Objectives Of The Health Program

The objectives of the health program may be an iteration of the system's health objectives. If objectives have never been formulated, this is the time to do so. The primary objective should be to provide good quality health care on a timely basis in a cost-effective manner. One strategy for attaining this goal may be to meet the health standards of the National Commission on Correctional Health Care, the American Correctional Association or another standard-setting body and to comply with state regulations regarding licensure of health staff and facilities.

C. Determining the Information Needs

The success of the planning will depend on the accuracy of the information that is available or is generated. It is necessary to know what kind of health conditions exist in the system's population in order to predict what kind of needs must be met as well as the staff, equipment and space needed to provide the specific health services. For example, it is important to know how many inmates are expected to come to sick call daily in order to determine the size of the inmate waiting area. Further, experience with the health needs of specific age groups will help determine the extent of special needs and whether they can be met in the health unit or will need to be referred to the community. Additionally, the cost of ancillary services (e.g., laboratory, radiology) in the community may be less expensive than providing them in the health unit.

The options on where and how to provide which types of health care, therefore, rest on a number of variables that must be identified and analyzed if informed decisions are to be made. The listing below indicates the types of variables that need to be considered and the data that should be gathered. With respect to the first section below, care should be taken to ensure that the data reflect anticipated population needs and utilization, and are not based on what existing resources can handle.

1. Inmate Health Profile and Utilization of Health Services

a. Population characteristics: health profile correlated with age, gender (if

co-ed use of the health unit is planned) and security level.

b. Frequency of medical service provided by category of complaint (e.g., general, chronic, dental, dermatological, mental health).

c. Average daily number of inmates scheduled for sick call.

d. Average daily number of inmates seen by the physician(s).

e. Average daily number of inmates seen by nurses.

f. Average daily number of inmates seen by the mental health providers.

g. Average daily number of inmates seen by the dental department.

h. Average monthly referrals to community providers (e.g., diagnostic services and specialty consultants).

i. Average daily census in medical and mental health infirmary beds.

j. Community hospital days (for both medical and mental conditions). These can be calculated on an annual basis. If experience points to a particular condition as using the most hospital days, this should be noted in the planning.

k. Annual number of emergency transfers (both within the system and to community hospital emergency departments).

2. **Health Resources**

a. Health resources within the system: specific institutions and their medical facilities.

b. Health resources in state agencies: facilities that are available for diagnostic and inpatient care.

c. Community hospitals, clinics and consultants.

3. **Cost Estimates**

a. Staff costs for the health unit (medical and custody).

b. Equipment costs for the health unit.

c. Transportation costs for all prisoner-escorted trips for health care (emergency and routine) including security costs.

d. Costs for all community services including diagnostic services, hospital days and specialty consultants.

e. Other costs if any.

D. Analyzing the Data

The planning committee will need to analyze the information from section C. above and develop expectancy tables, resource lists, staffing categories and salaries, and cost estimates by service, so that it can chose options. The discussion below addresses some of the analyses that should occur.

1. Population Characteristics

The health profile of the system's population should provide information on the kinds of medical conditions and their frequency, e.g., per 100 inmates. It should be possible to determine the conditions that can be expected in a population by age category (e.g., an older population can be expected to have more heart disease, hypertension and diabetes than a younger one, while younger inmates will have more sports-related injuries); and by gender (e.g., women will need obstetric and gynecological services). Also, inmates' security levels should be considered in projecting utilization data, if they affect staff and space considerations. For example, some maximum security inmates may be brought to the health unit only one at a time. If the prison has a large number

of such inmates, fulfilling their health care needs will impact on the utilization of staff and space and their availability to serve the rest of the population.

Where the planning is for renovation of an existing prison's health unit, the experience of that unit may be used in developing an inmate health profile; however, the usefulness of this information is dependent on the stability of the composition of the population. If the mission of the prison is changing (e.g., it will house short-term pre-release inmates instead of longer term inmates), the population profile for the facility based on the previous inmates held will not be valid. In this instance, a systemwide health profile may be more appropriate in determining health needs at the individual facility level.

Some systems use medical classifications (e.g., Class I through IV, or the military PUHLES system). Although such classifications can provide a useful base from which to develop a health profile, they are not sufficient unless particular health conditions are specified.

2. Evaluating Health Resources

A health unit often requires support services either from other prisons in the system or from the community or both. A correctional health unit, unless it is unique, also will require the use of other medical resources for diagnostic procedures that may involve specialized staff or expensive equipment. Thus, it is necessary that an inventory be taken of the health resources available within the system as well as those in the community.

If the planned renovation of the health unit or construction of a new institution is to be located near an existing facility, the resources of the neighboring facility should be reviewed. Will the existing resources be adequate to handle the additional health needs of the new/renovated facility in terms of space and staff? If a new institution is being planned near a community that does not have a prison, an assessment of its resources will be necessary. Additionally, it will be necessary to ascertain whether those resources will be available to the prison, since some community hospitals and clinics are not willing to accept inmates as patients. If the new institution is based on an architectural prototype, the levels of care and staffing already may be set. It is still necessary, though, to assess the community resources, since they may differ at the new location.

In the case of a non-prototype facility, using the staffing pattern from an existing health facility is premature, since the level of care has not been determined. When the levels of care have been set, the staffing pattern of other units may be used as a reference with the *caveat* that other factors may not be similar. For example, the inmate health profile may differ, needed medical specialties may not be available at the proposed community hospital, other prisons' health units may be too distant to use economically, or there may be problems with staff recruitment owing to competition with the private sector or to a lack of health professionals of specific types in the community.

3. Comparing Costs

a. Staff

With respect to staff, the planning committee should have a listing of all approved or planned health positions and their salary costs plus fringe benefits. The listing should include custody staff who will be used to provide security in the health unit as well as inmate escort services. One reason for compiling this list is to ensure that adequate space is provided for all staff (see section G of this chapter). This information also is necessary in order to make accurate comparisons with the cost of using community services or consultants. A consultant may be contracted with for the time needed at a lower cost. A permanent position is a continuous expense in salary and fringe benefits. The cost of an external referral may seem high, but it may be less expensive than the equipment, supplies and staffing for a permanent position.

Each full-time position should include a relief factor to allow for sick time, continuing education, vacations and holidays. The factors often used are 1.2 for each five day per week full-time position and 1.7 for each seven day per week full-time position (e.g., 3 five day per week positions = 3 x 1.2 = 3.6 or 4 persons to fill the 3 positions).[1]

b. Equipment

The planning committee should have an equipment list for reference (see sample provided in Appendix J). Medical equipment catalogs include descriptions, costs and dimensions. Catalogs are useful in determining costs and later can be used in defining spaces and space dimensions for equipment. It is recommended strongly that no major equipment

purchases be considered without serious discussion relating the need of the equipment to the inmate population health needs and doing a cost comparison of purchasing the equipment and hiring trained staff to operate it versus purchasing the service in the community. For example, dialysis machines and radiological equipment both require large capital outlays as well as specially trained operators and can be expensive to maintain. Unless the volume of patients requiring these special services is large, it may be more cost-effective to purchase these services from a community provider rather than purchasing the equipment. If the planning is addressing renovation, existing equipment should be surveyed and evaluated as to its appropriateness and condition.

c. Transportation

Transporting inmates to external health resources for routine services incurs costs for both mileage and custody staff salaries. Both must be considered in any calculation comparing the cost of external versus internal services.

Transportation: Will the facility purchase and maintain its own equipment (e.g., ambulance, other specialized medical transportation conveyance)? What is the capital cost of such equipment and its annual maintenance expense? Is private transportation available and if so, what is the cost based on the projected number of trips? Will other vehicles owned by the agency be used and if so, what is the projected mileage cost at the agency rate?

Staff: The salaries of custody staff used to transport prisoners to external health resources and to guard them during their stay are an expense chargeable to health care. Average hourly costs for security should be calculated from the time the inmate leaves the prison until s/he is returned. Also, if the sending facility will make extensive use of another facility's health program in the system, staffing increases must be considered at the receiving unit to assist in handling the increased workload.

d. Community care

In addition to transportation costs, it is necessary to determine staff costs for security during hospitalization, the cost of diagnostic procedures and any laboratory work not done on site, the anticipated hospital days per year and the cost of hospitalization, and the cost of outpatient specialty services.

Costs associated with community care can be based on the experience of like populations and comparable facilities and can be computed on a per 100 inmate basis, on an average cost per unit or on an annual basis. Whichever method is chosen should be used consistently whether computing the number of trips, average mileage per trip, the number of referrals by specialty or the average cost per referral. Annual figures should not be mixed with unit cost figures.

e. Other Costs

In any given system, there may be other costs that will have an impact on the planning process and the decision-making regarding the proposed health unit. If so, these should be considered as well.

E. Determining the Level of Care and Services

At this point, the planning committee should be in a position to define the level of care that will be provided at the new facility and to determine the health program components. The following information will have been assembled:

- Health profile of the inmate population at the proposed facility.
- Expected volume of inmates for sick call, diagnostic referrals, chronic clinics, infirmary care, specialty services and hospitalization.
- Health needs of the inmate population.
- Health resources of the correctional system.
- Related health resources of other state agencies.
- Health resources in or near the community where the facility is to be located.
- Estimated costs of transportation for all external services.

- Cost of additional staff for the provider institution, if existing system resources are used.
- Cost of diagnostic services in the community.
- Hospital or clinic costs by specialty.
- Specialty consultant contract costs.
- Full-time medical and support positions, salaries and fringe benefits.
- Other costs.

The decision as to the level of care that will be provided at the prison's health unit is best reached by balancing inmate health needs with system and community resources. In most instances, the options will be limited to deciding between a clinic only or a clinic with the addition of an infirmary. In some instances, though, special purpose units may be planned such as psychiatric facilities, geriatric units, handicapped facilities or hospice-type units for terminally ill patients.

If the new health unit is in a cluster of institutions, it can be planned to function as part of a regional medical system, with each facility providing specific services. It may be that one facility already has sufficient infirmary beds, specialty clinics, and radiology and laboratory services to absorb the new population and another has sufficient inpatient mental health services. The new facility then could be limited to providing its own clinic care. On the other hand, if the planning process indicates that the infirmary at an existing institution is inadequate owing to lack of space and lack of expansion potential, it may be prudent to build an infirmary in the new facility that can handle the overflow from existing institutions. In the latter case, the level of care will not be determined solely on the basis of the new facility's population, but also on the assessment of the needs and resources of all the facilities in the cluster. All options must be considered carefully, including potential economies of scale.

To determine the unit's level of care, it is advisable to identify all of the services that will be available to the inmate population irrespective of where they will be provided. The options for on-site versus external services then can be considered. The list below identifies many of the components of the medical program for a clinic or a clinic/infirmary. Each of the activities or services listed has implications for staffing, space or equipment needs or all three.

1. Initial reception: If the prison is a receiving institution for new admissions to the system, it will need to provide all the intake health functions including physical, mental and dental examinations and evaluations (all of which may require diagnostic tests and procedures).

2. Intra-system inmate transfers: Intake of transfered inmates at the receiving institution will require, at a minimum, chart reviews and follow-up of ordered care.

3. Sick call: The anticipated volume of sick call and the frequency with which it will be held should be specified as well as who will conduct it, where and how.

4. Chronic care: The types, location and scheduling of the chronic clinics should be described.

5. Convalescent care: If this care is to be provided by another facility with an infirmary, this should be stated. If such care will be provided in this health unit or in special housing outside the medical unit, this should be indicated.

6. Infirmary Care: If the health unit will have an infirmary, the number of beds should be determined based on anticipated need. If the infirmary will serve other facilities also, the number of beds should reflect this. The national standards selected to guide health services operations should be reviewed for other requirements (e.g., 24-hour nursing coverage) that will affect the space and location of the infirmary.

7. Medical isolation: The experience with infectious diseases systemwide may be useful here, since this figure may show trends. Isolation for tuberculosis and other airborne diseases will require a negative pressure room to minimize transmission of infection.

8. Laboratory: Will the unit support a laboratory for basic procedures, send all work to an outside contractor, use the services of another facility in the prison system or do all three? The complexity of the lab work to be done in-house will determine equipment and space requirements.

9. Pharmacy: The anticipated volume of prescriptions, storage space, security, refrigeration, temperature control and ventilation are considerations that need to be addressed.

10. Medication distribution: A "keep on person" program may reduce, but will not eliminate the need for medication call. Will the pharmacy also serve as the place for distribution of medication? If medications are to be distributed to inmates through a window to the yard, will cover from the elements be needed? If the medication distribution is done in an area(s) separate from the pharmacy, consideration of space, storage, ventilation, temperature and security of medications is needed.

11. Mental health care: What is the anticipated patient volume? Will acutely ill inmates be transferred to other facilities for observation and care? If not, how many psychiatric inpatient beds will be needed? Also, "safety cells" for observation of dangerous psychotic or suicidal inmates will be required.

12. Dental care: What is the anticipated patient volume? How many operatories will be needed? What other types of equipment will be required (e.g., x-ray machine, developer, full mouth x-ray machine)? Will dental lab services be provided on-site? Where will oral surgery needs be met?

13. Medical consultants: Will inmates be referred to community facilities or will medical consultants be used at the prison? In the latter case, what is the anticipated volume and probable scheduling for specialty clinics? Will the space be multi-use? What are the anticipated equipment needs? Where will any special equipment be stored when not in use?

14. Emergency services: Equipment and space requirements for an emergency room should be provided. Will this be a multi-use room, serving as a treatment area unless needed for emergencies? Also, will the facility operate its own ambulance service? If so, any special space and equipment needs should be considered.

15. Medical records: Space requirements for storing both active and inactive records as well as offices for medical records personnel must be determined.

16. Administrative offices: Offices for various staff (e.g., physician, director of nursing, physician extender, psychiatrist, psychologist, health administrator), must be identified as well as working space for support staff. Combination office/exam rooms for medical staff and office/treatment rooms for mental health staff should be considered to save space.

17. Storage: Space requirements for storage of medical supplies must be determined. Additionally, if there is to be an inpatient area, storage for both clean and dirty linens will be needed.

18. Radiology: The options here are a) all but the more sophisticated work is done on-site; b) a portable service is provided; or c) all services are provided by another institution or community facility. Options a) and b) will require equipment and space on-site although the portable x-ray may require less space.

19. Segregation/confinement: How will inmates in segregation be provided medical care? Will sick call be held in the cell block in a dedicated examination/ treatment room? Will inmates be brought to the medical unit in all instances or only for treatment? What are the staff and space requirements for the different options?

20. Hazardous waste: How will this be managed? Will there be space and/or equipment requirements for this program?

21. Other: Decisions are needed also regarding staff and inmate toilets, inmate waiting areas and whether a staff locker room/lounge and a conference/ training/library room will be included.

Note that not all the possible services are dealt with here; for example, special provisions for the physically handicapped have not been mentioned. Nonetheless, it should be clear that all the national standards and state licensing requirements that have space, equipment and/or staff components must be addressed in order to identify all the health functions and space needs for a given prison unit.

F. Developing The Architectural Program

Up to this point, organizing the planning process, determining the information needs, analyzing the data, and deciding the level of care and services that will be provided on-site have been addressed. By now, the planning committee should have a thorough understanding of the system's health program needs and resources and should have identified the level of care of the new/renovated unit. The next step is to develop the architectural program.

The architectural program is a conceptual model that describes the health program to the designer. It includes the objectives to be achieved by the design, a brief description of the activities within the health unit, and the function of each space as well as its contents and dimensions. In order to generate a configuration of the spaces, the designer needs to know the volume and flow of traffic, high and low use areas, density, staffing patterns, and special considerations such as security, inmate supervision, emergency needs, placement of equipment, storage requirements and contaminated waste disposal procedures. This listing is not exhaustive, but illustrates the variety of functional and program concerns that the planning committee must address, if the architect is to receive the information needed to produce a workable design.

The architectural program must be expressed in clear, understandable, unambiguous language. It must include concise descriptions of the functions and dimensions for each space. Terms such as "occasional", "usually", "adequate", "sufficient" and other adjectives indicate that the writer has no idea about what is being described. Neither will the designer.

The primary components of the architectural program from both the health and security administrators' perspectives are addressed below.

1. Health Components

a. Objectives

The planning committee will have formulated the objectives of the health program and will have determined levels of care and identified the program components. A strategy for achieving health care objectives may be to meet the standards of the National Commission on Correctional Health Care or those of the American Correctional Association, American Public Health Association or the Joint Commission on Accreditation of Healthcare Organizations. It is recommended that the National Commission standards or those of another standard-setting organization be used as the framework for the development of the health program description.

b. Health program description

The committee is now ready to describe for the architect the types of spaces that will be needed. The list in section E of this chapter addressed the components of the medical program for a clinic or a clinic/infirmary. Decisions as to on-site and off-site services will have been made and can be described in a written document. In all instances, the planning committee needs to review whatever standards have been selected and describe the program that will be implemented to meet them. The description should address anticipated volume of use (high and low), the space needed for the program component (if the space will have multiprogram use, this should be indicated), how many staff will use the space, and equipment and storage needs of the space.

2. Custody Components

The above discussion addressed the program needs of the health unit. The custody components address the problem of locating the health unit so that it meets the institution's requirements. These may have an effect on the medical program, but should not distort it. These requirements include access, security and emergency planning.

a. Access

The health unit should be located in an area that is secure and yet one that is easily accessible. The selection of the location may be a compromise, since an optimally secure location also may be difficult for inmates, staff and emergency vehicles to access. Ideally, the health unit should be placed in a site where it is separated from the normal inmate traffic flow and secured from entry by its own sally port. Placing the health unit on the perimeter of the institution provides easy entrance and exit for health professionals and emergency vehicles. Such an arrangement, however, may require additional custody staff. In any case, the health unit should be located on the ground floor to ensure ease of access for handicapped inmates and for exiting patients from the compound.

b. Security

The security component of the program should address the following:

1) Control of inmate entry to the health unit. This implies security doors and hardware controlling entry, windows, and emergency exits; security staffing and control posts for the medical unit; and emergency communication equipment.

2) Location and capacity of inmate waiting area. The inmate waiting area can be inside or outside the health unit. It should be in a location, however, that does not interfere with traffic in and out of the health unit. Hallway benches are unacceptable. Such placement often leads to inmate interference with staff movement, harassment of staff and other inmates by waiting inmates, and other inmate control problems.

3) Inmate supervision within the health unit. Security concerns include supervision of inmate/ patients (and inmate janitors, if used); security of medications, drugs, sharps and needles; lines of sight; and supervision of inmates in the infirmary. The location of the custody officer(s) within the health unit should be indicated.

c. Emergency considerations

Specifications for emergency exits from the unit should be developed that include time and distance requirements, and areas to which individuals can be evacuated. Other requirements to meet fire and safety codes must be addressed. Emergency vehicle access (including helicopter landing space if air evacuation is to be used) must be planned.

G. Summarizing the Design Needs

1. Dimensions and Spaces

Up to this point, the planning process has concentrated on program description, functions of spaces, volume of inmates for services, options on delivery of services, equipment and its dimensions, and staffing. Multi-use spaces were discussed for the delivery of different services (e.g., specialty clinics, chronic care clinics). Now it is necessary to identify the specific number of spaces, their dimensions and whether they will be single use or multi-use. A checklist such as the one shown as Exhibit X-A may be a helpful first step. A summary based on the checklist is the second step.

Each of the space categories reflected in the summary should include detailed information that clearly indicates the activities that will take place, how many persons will be required for each activity, hours when the space will be in use and for how long a period, and the dimensions or square foot requirements of equipment, staff etc. Since the checklist does not provide enough space to include such detailed information, a different format is needed for the written description. The page layout for this summary might be as follows:

a. Treatment/Examination Room One

1) Functions
2) Use (schedule)
3) Density (maximum)
4) Equipment (types & dimensions of each)
5) Total dimensions (gross square feet)

EXHIBIT X-A

DESIGN NEEDS CHECKLIST

Spaces	Function	Density*	Dimension**

Treatment/Examination Rooms (list each)

Emergency Room

Offices (list each)

Infirmary Rooms
(list each and specify number of beds and use, e.g., isolation, safety cell, handicapped equipped, general)

Dental
(list operatories, lab area, x-ray equipment space)

Laboratory

Pharmacy

Radiology
(include equipment area, developer area and file space)

Medical Records

Storage (all types, list each)

Waiting Room(s) (and holding cells if required)

Rest Rooms

Staff

Inmate

Other Spaces
(e.g., physical therapy, locker room/lounge, conference room/library)

*Density refers to the number of people who will be using a space at any given time.

**Dimension should be measured in gross square feet and should take into account space required by equipment and working area.

b. Treatment/Examination Room Two (etc.) (Repeat same information as in a. above for each room of this type.)

c. Emergency Room One

1) Functions
2) Use (intermittent and unscheduled)
3) Density (maximum)
4) Equipment (types & dimensions of each)
5) Total dimensions (gross square feet)

The description continues until all program spaces have been defined for the designer.

This listing is a recapitulation of the subprograms in section E above. The major difference here is that it clearly lists the number of spaces with their dimensions and is useful to the designer for quick reference. It also ensures that no space is left out.

2. Traffic Pattern

This is probably the most difficult phase of the planning process. The traffic pattern is the heart of the design and the element that can make a program work well or cause continuous problems. The number of offices and special purpose rooms can be determined with precision; the way they are arranged to expedite the flow of activity (i.e., their functional relationship) is not precise, but it is critical to the work activity:

> *The term functional relationship here emphasizes relative physical proximity of one activity to another. Time spent transporting people, materials, and equipment from one functional area to another is often critical. The importance of physical proximity can be evaluated by analyzing traffic flow. The need for close functional relationships may result from volume of interactions between functions, or dependence of one function on another* (Hayward, 1985).

The writer was referring to hospital planning, but the concept of functional use and space planning is applicable to correctional health units. In correctional facilities, where space needs are at a premium, the need for careful planning for the use of space and the location of the various work areas is crucial. For example, placing the radiology service where it is easily accessible to the treatment rooms seems rational; however, if the only entrance to radiology is through a treatment room, the traffic pattern through the treatment room will make that room useless at certain times. On the other hand, limiting traffic through the treatment room will reduce the value of the radiology room. Use and traffic patterns mandate that there be access to radiology from both the treatment room and an outside corridor, if proximity of these two functions is to be accomplished. Three factors are important in determining traffic flow: functional relationship, pattern of use, and volume. Security and control underlie all three of these factors. *Functional relationship* refers to related functions and the need for them to be close to each other. *Pattern of use* is the times during which a functional area is being used. *Volume* refers to the number of persons who will be using that space at one time and the number of persons who will be using the space over a specific period of time (e.g., the treatment room will be used by approximately 70 persons daily, but the maximum number occupying it will be no more than three at any given time: physician, patient and nurse).

The placement of each program space will need to take into account:

a. functional relationship: what related activity or resource will be needed to support the activity? The functional relationship may be with radiology, health records or laboratory services.
b. pattern of use: what are the peak hours during which this space will be used?
c. volume: what are the total number of persons using the room daily and the maximum number served at one time?

One method of roughly determining the traffic pattern is to list the major health program areas and enter the volume for each using an average daily figure. The format shown on the next page may be useful in developing a first cut of the traffic pattern.

Space	Anticipated number of inmates treated daily	
Medical Screening	10	
Treatment/Examining Room	70	
Laboratory	10	
Radiology	10	
Mental Health		
Individual therapy	20	
Group therapy	30	(3 groups of 10 each)
Dental	16	
Specialty Use (consultants)	10	
Pharmacy (pill window)	175	
Emergency Room	4	

The above listing is not exhaustive, since some programs may include a hydrotherapy room, for example, or other areas with dedicated purposes (e.g., physical therapy, nutrition center for inpatients). It is doubtful that there will be any surprises as to where the volume of use is located. This scheme, though, will help clarify the areas of use and begin to suggest a traffic pattern. The information will need to be correlated with the functional relationships of the various program elements.

One other consideration that needs to be addressed is the traffic pattern of the staff. To a great extent, it will follow the volume of inmate use of services; however, there are some exceptions. For example, location of the medical records, the pharmacy and the infirmary will not necessarily follow inmate use patterns. Inmates should not be allowed in the medical records room or the pharmacy and there will not be 100 percent turnover of infirmary patients daily. Further, the location of the emergency room is not dictated by volume, but by easy staff accessibility and an unimpeded exit to emergency vehicles.

In determining the traffic pattern, the following criteria should be considered:

a. Limiting the access of inmates to the interior of the health unit.

b. Locating the services with the least volume toward the interior.

c. Placing those support services used by the staff centrally to minimize distance and facilitate ease of use.

d. Situating the inpatient and isolation areas out of the heavy traffic pattern to provide maximum supervision and eliminate outpatient contact.

e. Setting the inmate waiting area out of the normal traffic pattern to limit interference with health staff, but within observation of security.

3. Architectural Program Statement

The architectural program statement is a document that describes the health care program, its objectives, needs, and the decisions that have been made in selecting health care delivery service variables. It includes statistical information that supports the decisions and contains specific instructions to the designer on program needs, space needs, dimensions, functional relationships, volume and density. The committee also may include instructions that represent policy considerations not addressed by the study.

Organization of the architectural program statement may vary. The outline below is suggestive.

a. Introduction

1) Objective of the health care program
2) Population health care profile
3) Health care resources

b. Location of the Health Care Unit

1) Needs of patients and health staff
2) Administrative concerns
3) Security concerns
4) Emergency considerations

c. Description of the Health Care Program

1) Level of care
2) Health care program components and options
3) Staffing
4) Equipment
5) Costs

d. Program and Space Specifications

For each component, list:

1) Space name (e.g., examining room).
2) Function: Concise statement of how space is to be used.
3) Location requirements: The description should include volume of use, how often used, functional relationship to other activities and security needs.
4) Density: maximum number of persons accommodated.
5) Equipment: types and dimensions including cabinets, sinks, file drawers, desks, examining tables, dental operatories, beds, storage equipment, computers and office equipment, specialty needs and the like as appropriate to the function of the space.
6) Space dimensions: specify the size of the overall space as well as the working area required when equipment dimensions are taken into account.
7) Dimensions of openings: type and dimensions of doors (some should be wide enough to admit a stretcher, gurney or hospital bed) windows (some rooms may need greater visibility or special glass) and other openings.
8) Privacy requirements: e.g., examining rooms, emergency rooms.
9) Sanitary facilities: ratio per employee and per inmate and location.

e. Summary

In addition to the clinical spaces, it is recommended that the health unit include space for a staff lounge/conference room that can double as a training room. Also, as discussed earlier, space must be provided for staff offices, so that paper work can be completed.

By now, the job of the planning committee is completed for the most part and the work of the architect begins.[2] S/he should have a thorough understanding of the health unit's functions and requirements and it is his/her responsibility to translate the program statement into a workable design.

H. Post-Design Considerations

1. Occupancy Of The New Unit

If the health unit is part of a new institution, an occupancy schedule and training plan should be included in the overall occupancy plan. The planning committee members may not necessarily develop the training plan, but they have a responsibility to make the assignment and to develop a schedule. Training should occur after completion of finish work and the placement of equipment. It should include orientation to the new facility as well as the health unit. A review of the architectural program statement with the proposed staff for the new unit is one method of beginning the orientation. Space should be identified and offices assigned. Policies and procedures should be reviewed and modified where necessary to meet the new unit's needs. Normally, the system's policies will remain in force, although some procedures may change based on the local prison's needs.

Training should provide the staff with an opportunity to become familiar with the physical organization of the facility and the health unit, and include testing of new equipment. If staff members are new to the correctional system, it is expected that a comprehensive training program will be available.

2. Post-Occupancy Evaluation

A post-occupancy evaluation of the health unit should be conducted approximately six months after it is opened, in order to test the effectiveness of the design. The following criteria should be reviewed:

a. Have inmate control and supervision been achieved?

b. Is traffic flow according to predictions?

c. Has organization of the spaces resulted in an efficient work flow?

d. Is there sufficient work space within each room?

e. Is the equipment functioning as planned?

f. Are there any other areas of design weakness?

A questionnaire should be developed and health and custody staff interviewed in order to conduct the evaluation. Questions should be based on the areas listed above. If they are to be useful, positive or negative responses should be supported with detailed information, and in the latter case, with suggested alternatives to the existing design components.

The results of the evaluation should be submitted to the administration and should be available for future planning. If another health unit is anticipated, this information should be reviewed in order to further reduce planning and design errors.

ENDNOTES

1. See Chapter VI on staffing for more information on calculating personnel needs and developing staffing patterns.
2. It is difficult to specify the exact time when the architect enters the process. As soon as the architect has been identified, though, s/he should work with the planning committee.

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CHAPTER XI

DATA MANAGEMENT AND DOCUMENTATION

The importance of accurate data and information upon which to assess current activities and plan future programs has been stressed throughout this book. This chapter identifies the key types of documentation required in any correctional health system. Section A addresses the development of a policy and procedure manual while Section B reviews the components of an adequate health record. Section C identifies the types of data needed for administrative purposes and Section D describes data collection and management techniques. The efficacy of utilizing computers in data management and documentation activities is discussed as well.

A. The Policy and Procedure Manual

Establishing a written policy and procedure manual to govern correctional health services is essential. If one does not exist, its development is the first step the statewide health services director should take to improve the system of care. The primary purpose of a written policy manual is to define clearly the DOC's position regarding specific issues including administrative matters, personnel requirements, the care and treatment of patients, and the services provided. It translates the health services division's basic goal (i.e., to provide quality health care to inmates on a timely basis in a cost-effective manner) into a series of statements that define how that goal is to be achieved. In effect, a written policy manual is the DOC's own set of standards against which it can measure the extent of compliance at individual institutions and at times, the performance of specific staff members.

The health services policy and procedure manual serves both as an operational guide for current staff members and as a training guide for new employees. While the development of a comprehensive manual is time-consuming, its existence saves time in the long run since it is no longer necessary to explain verbally (often repeatedly) the exact steps involved in, for example, holding sick call or completing a specific form. More important, written policy statements help to ensure standardization. The same information is communicated to each health services staff member in the same way, which helps to assure uniform compliance with policies and accuracy in the completion of documentation requirements. Another advantage of a written policy manual is that it is available for ready reference. It can resolve disputes among staff members regarding procedural issues and assist in decision-making as to whether an inmate's specific request for care is allowed. Finally, a written policy manual can be extremely useful in defending a lawsuit against the system and is a requirement for accreditation by national organizations.

In developing policies and procedures, there are a few basic rules that should be kept in mind. First, the written statements should reflect the DOC's actual positions and practices. In other words, they should state what is in effect now and not what someone hopes will be in effect a year from now. To do otherwise not only makes the policy manual meaningless as a management tool, but also can invite litigation charging that the DOC failed to live up to its own standards.[1] When a change is made in the DOC's position or procedure, the policy statement can be updated so that it always reflects current practices. Second, policies and procedures should be designed to cover the usual situation and not the unusual one. It is difficult if not impossible to address every eventuality in a policy statement on a specific topic. Exceptions and questions are sure to arise when policies and procedures are implemented. That is as it should be. A policy manual is not a static document. It should be reviewed regularly and input from users should be solicited to determine whether clarifications or changes are needed. Third, it is important to be as specific as possible. The more detail that is provided, the greater the chances are for uniform compliance. Fourth, the imperative mood should be used. If compliance is optional, it is not a "policy" of the DOC, but only a recommendation.

One of the first steps in developing a policy and procedure manual is to list the topic areas that will be included. Reviewing the table of contents of APHA's and NCCHC's standards can assist with this task. Once this decision has been made, the actual writing of the policies and procedures can be assigned to specific staff members with expertise in the content areas or delegated to a multi-disciplinary "policy and procedure committee." A consistent

format should be used for each policy statement that incorporates the following key elements:

- The title of the policy and procedure.
- The date it goes into effect.
- The page number out of how many pages (e.g., page 1 of 4).
- The name of the department, division or issuing agency promulgating the policy and procedure.
- The application (e.g., when there are institutional differences, this space indicates the institutions to which the particular policy and procedure applies).
- The number of the policy and procedure.
- The policy statement itself.
- The procedures that specify how the policy will be carried out including who does what, when, how and sometimes, how often and for how long.
- Cross-references to other relevant policies, if any.
- References that support the policy including national standards as well as state laws, rules and regulations or agency directives.
- The signature(s) and title(s) of the authorities who approved the policy statement.

If the policy and procedure involves the completion of a form, blank copies of the form and instructions for its use should be appended to the policy statement. Examples of policy statements that incorporate these key elements are provided in Appendices A and K.

When new policies and procedures are drafted, it is useful to send them out for review prior to implementation. Drafts should be circulated not only to relevant staff in central office (including non-health staff), but also to selected custody staff and health professionals working in the institutions. The latter, as potential users of the policy and procedure statements, often are in the best position to comment on the clarity and feasibility of the proposed statements. Lindenauer and Lichtenstein (1979: 13) suggest that procedure statements be reviewed with the following questions in mind:

(1) *Does the procedure address policy objectives?*

(2) *Is the procedure realistic?*

(3) *Is the procedure adequate?*

(4) *Are all relevant contractual arrangements/requirements covered?*

(5) *Are other policies and procedures compatible with this one?*

(6) *Are procedural steps in the best order?*

(7) *Is the sequence unnecessarily rigid?*

(8) *Can any steps be eliminated?*

(9) *Does the procedure avoid bottlenecks?*

(10) *Are the steps designed to operate at the lowest level of authority?*

(11) *What is the effect of proposed changes on other procedures?*

(12) *Will the procedure work on all shifts?*

Once the policy and procedure statements have been reviewed and revised, the next step is to train relevant staff in their use prior to the actual date(s) of implementation. Depending upon the number of statements, this can be accomplished at special in-service training sessions or as part of the regular shift change notification process. Regardless of the approach, potential users on all shifts need to be aware of the pending policies and the date(s) of implementation. It also is a good idea to notify custody staff of proposed changes (except for those totally internal to health services) so that they are kept informed of general health services procedures. Obviously, if the proposed policy involves coordination with custody staff, they should be included in the development, review and training processes.

The organization of the policy manual is another consideration. Some DOCs group their policies within specific program or service headings (e.g., medical, dental, mental health, pharmacy) while others elect to follow the organizational format headings of NCCHC's standards or some other set. Regardless of the approach taken, each policy manual should include both a table of contents and an index. The table of contents simply lists the title of each policy statement in the order in which it appears in the manual according to whatever numbering scheme has been selected. The index is arranged alphabetically by key words and lists all policy statements by number that pertain to that key word. The larger and more complex the policy manual is, the more important it becomes to have a good indexing system. Since the policy manual serves as a training and reference book, ease of use is a primary consideration.

The distribution and placement of the health services policy manual are important as well. At central office, copies should be provided at least to the heads of each department/section within health services, the director of the agency and to the heads of other relevant divisions within the DOC such as custody, classification and food services. At the unit level, the warden/superintendent, the health services administrator and the clinical director should have copies, and copies should be placed in each health services office area for ready reference by staff. A complete distribution list should be maintained by a health services staff member at central office along with instructions as to who is responsible for ensuring that the unit policy manuals are kept up-to-date. The manual should be reviewed at least annually and revised as necessary.[2]

Before leaving this section, there is one final *caveat*. Users of a policy manual always should keep in mind the intent of a policy statement. As noted above, policies are written to address the usual situation. Occasionally, unexpected circumstances may make it impossible to follow a policy and procedure exactly. When that occurs, the staff member must make a decision as to whether it is better to deviate somewhat from the specified procedure or not to comply at all. For example, suppose one of the procedures in the DOC's policy on medication distribution specified that "medications must be distributed only by an individual licensed at the LPN level or above." Suppose further that on a given day on a given shift, the only health staff member available was an EMT. Would it be better for the EMT to deviate from standard procedure and go ahead and pass the medications or for him/her to adhere strictly to the procedure statement resulting in inmates not receiving their medications? The answer should be obvious. If the EMT chooses the latter course of action, s/he would be guilty of what some have termed "malicious compliance" with policy.[3]

When faced with an unexpected situation where deviation from a procedure is necessary in order to comply with a policy, the health staff member should ask:

- What is the intent of the policy?
- What are the potential negative consequences if I deviate from the procedure?
- What are the potential negative consequences if I do not comply with the policy at all?
- Can I deviate from the procedure and not violate the scope of my own licensure, certification or registration?

The answers to these questions should indicate to the staff member whether the better course of action is to deviate from the procedure or not to comply with the policy. When in doubt, clarification always can be sought from the individual's supervisor or the health official on-call. The bottom line is that when faced with a possible exception or deviation from a written policy statement, health services staff members are not expected to suspend their common sense.

B. The Health Record

The DOC's policy manual establishes a framework for the health delivery system that is generalized across all institutions. The health record is particularized. It summarizes all health encounters for a specific inmate. While the format and basic contents of the health record (i.e., the forms used) should be standardized across the DOC, the specific content reflects the assessment, care and treatment provided to individual patients. Basic issues associated with the development and management of health records are discussed briefly below. More detailed information can be found in the manual by Gannon (1988).

1. Format

The primary purpose of the health record is not only to document the care provided to a specific patient, but also to facilitate communication among the various providers who treat a single patient. A unified health record system -- that is, a single record for each patient in which all providers make their notations -- is the best way to enhance continuity of care. Health staff sometimes resist moving to a unified record system. Undoubtedly, it is easier for each service (e.g., medical, dental, mental health) to have its own records and store them in their own treatment areas. The problem with this approach is that it is both less efficient and less effective than a unified record system. Inefficiencies include the necessity of each service duplicating basic health data on each patient (e.g., treatment history, allergies, medications) as well as duplicating health record resources (e.g., folders, files, storage space, staff). Separate recordkeeping systems are also less effective than a unified system, since the former require constant communication among the services to alert each to any current treatment being provided to a patient by another service and thus, allow greater opportunity for error. With a unified record, any provider can see at a glance what medications and treatment have been prescribed by others for the same patient.

The organization of the forms within the unified record should be standardized. Gannon (1988) citing Huffman (1985: 66) states that "there are three types of format: source-oriented, problem-oriented and integrated." In a *source-oriented format*, forms are organized into sections by the department that provided the care (e.g., dental, laboratory, radiology, mental health). In an *integrated format*, forms are filed in chronological order regardless of which department provided the care. The *problem-oriented medical record* (POMR) is separated into four sections: the database (i.e., assessment information about the patient's history, the physical exam, mental health evaluation, dental screening and diagnostic studies); the problem list (i.e., a summary of the patient's primary problems with notation as to whether they are on-going or resolved); the treatment plans (i.e., specification as to how the identified problems will be resolved or managed); and the progress notes (i.e., notations at each health encounter that indicate what follow-up has occurred in implementing the treatment plans). Both APHA's standards and NCCHC's standards recommend the POMR format.[4]

2. Basic Contents

The forms to be used in the health record should be standardized throughout the DOC. This is the only way to ensure that the same information is collected for each patient. Additionally, it is more efficient to reproduce copies of standardized forms than it is to allow each institution to create its own. Also, standardized forms are less confusing to health providers, which is an important consideration given that most DOCs transfer inmates to other institutions rather frequently.

To further enhance continuity of care, a standardized chart order for the health record should be adopted. It is a list of all approved forms to be filed in the health record that specifies in which section and in what order they are to appear. This simple step guarantees consistency in filing forms and makes it much easier for health providers to use the record. It also saves time since each provider, regardless of institutional assignment, knows exactly where to look in the standardized chart for a specific piece of information. Finally, a standardized chart order that lists the approved forms prevents the health record from becoming cluttered with extraneous memos and other materials.

While it is difficult to specify the exact forms that are needed in a health record, NCCHC's (1987: 44) standards state that:

At a minimum, the medical record file contains these documents:

> *problem list;*
> *receiving screening and health assessment forms;*
> *all findings, diagnoses, treatments, and dispositions;*
> *prescribed medications and their administration;*
> *reports of laboratory, x-ray, and diagnostic studies;*
> *progress notes;*
> *consent and refusal forms;*
> *release of information forms;*
> *discharge summary of hospitalizations;*
> *reports of dental, psychiatric, and other consultations;*
> *special treatment plan, if any;*
> *place, date, and time of each medical encounter;*
> *signature and title of each documenter.*

Gannon provides more specific instructions on the design and control of forms[5] and offers several examples of health record forms used by DOCs.[6]

3. Charting Guidelines

It also is useful to develop a standardized method of charting for narrative forms such as progress notes. The most widely used format is known as "SOAPing" or "SOAP notes." *SOAP* is an acronym that stands for the basic components that should be included in a progress note; namely:

Subjective complaint,
Objective findings,
Assessment of the findings, and
Plan for treatment.

Additionally, a list of approved abbreviations and symbols that can be used in charting is needed. This helps to avoid idiosyncratic notations that other providers do not understand and to reduce the possibility of errors in carrying out medication orders or treatment plans. For the same reason, it is imperative that clinicians be instructed to write legibly. It is both arrogant and foolish for them to scribble orders that others cannot read.

Providers who write in patient charts also should be instructed to include clinical notations only. The health record is not the place to make personal comments about one's patients or other providers. Further, professionalism must be maintained in chart notations. For example, it is not necessary to record for posterity the exact swear words an inmate called a provider. In fact, unless such exchanges have some bearing on the patient's treatment, they should not be recorded in the medical record at all.

4. Confidentiality

Clearly, the principle of confidentiality that is inherent in the provider/patient relationship extends to the health record and the information it contains. Distribution of health information must be restricted and access to the record must be strictly controlled. This is accomplished by ensuring that privileged health information is not disseminated to non-providers, by storing health records separately from custody records in lockable cabinets in secure areas, and by developing a list of the types of individuals who may view the health record. On the latter point, state laws and regulations may differ as to who legally may have access and what information may be discussed, so it is advisable to check the regulations in one's own state. Generally, though, access to health information and records should be restricted to health providers.

There are times when non-health staff members such as the person legally responsible for the facility are permitted access by law to certain health information about their charges. When a request to review a record from an authorized non-health staff member is received, it is best for a health services staff member to take the record to that individual and respond to questions as appropriate. This is preferable to sending the record by itself, since the health staff member can ensure that only information pertinent to the matter at hand is released. Additionally, the health staff member can locate the information more readily and interpret it as necessary for the lay person.

While inmates should be expressly prohibited from gaining access to other inmates' health records under any circumstances, the question sometimes arises as to whether inmates should be permitted access to their own health records. In her 1987 survey, Gannon noted that of the 37 state DOCs responding, 26 (70%) allowed inmates access to their own health records.[7] The American Medical Record Association (AMRA), which is a professional membership organization for medical record practitioners, supports the patient's right to access his/her own record.[8] It is advisable for each DOC to delineate a clear policy statement that addresses patients' access to their own health records.

5. Transfer of Health Records/Information

To enhance continuity of care, it is imperative that inmates' health records accompany them when they are transferred to another institution in the DOC. Health staff at the sending institution should:

- pull the health records of all inmates on the transfer list;
- review them to ensure that none of the people on the transfer list are on medical "hold";
- prepare a transfer summary that briefly lists current problems, medications, on-going treatment and any pending health care appointments; and

- secure the records in a locked box or some other mechanism so that they can be transferred with the inmates.

Health staff at the receiving institution should review all records of incoming inmates within a couple of hours of their arrival, do what is necessary to reestablish the inmates on medications and treatment programs, and reschedule health care appointments as appropriate.

For intra-system transfers of health records, it is not necessary to obtain a signed release of information from the inmates. If a request is received for copies of health records or information from an individual or agency outside the correctional system, written authorization from the inmate to release such information generally is required. AMRA has developed a model policy for the release of confidential health information that can assist health records staff at the DOC in writing their own policy statement.[9]

If an inmate is transferred temporarily to a community health facility for consultation or care, it is not advisable to send along the patient's DOC health record owing to the possibility of loss or damage. Instead, a referral form should be used that summarizes pertinent information about the patient and provides space for the community provider to note his/her treatment findings and recommendations for follow-up. The completed referral form should be returned to the institution with the patient and filed in the patient's chart.

6. Retention of Records

Jurisdictions differ with respect to legal requirements for the length of time that inactive health records must be retained. A written policy statement on record retention should be developed for each DOC that conforms to the legal requirements of that jurisdiction. It should specify where inactive records will be stored and for how long before they are destroyed. The policy also should indicate the procedure for re-activating the health record if an inmate returns to the DOC.[10]

C. Administrative Information Needs

In addition to the forms that comprise the health record, there are a series of other forms and recordkeeping systems that should be generated. In order to determine present system needs, evaluate the effectiveness of existing programs and services, and adequately plan for the future, much information is needed. By way of illustration, a partial listing of data and documentation requirements for effective administrative management, evaluation and planning includes those areas noted below.

1. Meeting Minutes

Minutes of regular meetings are one way of keeping administrators informed about the health services' operations at specific facilities including any problems that have developed and their resolution. Typical health services meetings that might be reported on include those between the warden/superintendent and the unit health services administrator, internal meetings of the health staff at both the unit and the central office levels, and meetings of various committees such as the pharmacy and therapeutics committee, the forms committee, the policy and procedure committee, the quality assurance committee, the infection control committee and the mortality review committee.

2. Budget and Cost Data

As noted in Chapter XIII, a budget is used to seek funds, plan program expenditures, and monitor and control expenditures once funds are allocated. The types of data needed to prepare a budget include those associated with defining patient need (e.g., size and characteristics of the population to be served); those associated with specifying services (e.g., type of services, number of personnel by type and level); and the identification of dollar resources needed to provide those services (e.g., number of full-time equivalent personnel by type and level at average annual salary of each, cost of equipment by number and type).

Once funds are allocated, actual expenditures in all line item cost categories need to be tracked and reported on periodically (e.g., monthly, quarterly, annually). For management purposes and cost comparisons from year to year, it is useful to break down expenditures not only by line item (e.g., salaries, fringe, consultants, travel, equipment and supplies), but also by program area (e.g., medical, dental and mental health); by service (e.g., hospitalization, specialty care, laboratory, radiology); and by characteristics of the patients served (e.g., age, gender, illness or condition). In more sophisticated systems, cost breakdowns may be available by specific procedures using standardized coding systems such as

CPT (Current Procedural Terminology) or ICD-9-CM or DSM-III-R or some combination thereof.

3. Personnel

The complexity of developing adequate staffing patterns for specific institutions as described in Chapter VI underscores the need for good data. Among the factors identified as influencing staffing patterns were characteristics of the institutions (e.g., average daily population, total annual intake, average length of stay, primary function); characteristics of the population (e.g., breakdowns by custody level, age groupings, gender, special health needs); characteristics of the health delivery system (e.g., number and types of services provided on-site, space allocations); and requirements of court orders or national standards. Additionally, administrators need to work out staff coverage factors and develop weekly or monthly schedules for employees.

Another recordkeeping system is needed to track orientation, in-service training and continuing education requirements for each health service employee as well as ensuring that licensure or certification credentials are kept up-to-date. In some systems, health staff are responsible for providing health-related training (e.g., first aid, CPR, suicide prevention) to correctional staff. Where this is the case, a recordkeeping system is needed to track compliance with training requirements for each individual correctional employee as well.

4. Inventories

Good management dictates that a variety of inventories are maintained. For example, equipment lists are needed that specify the type, model number, serial number, date of purchase and location by institution of every piece of health service equipment in the DOC. Such a listing is important for insurance purposes as well as to ensure accountability for state property. It also can be useful in deciding what basic equipment should be purchased for a new health service unit and in determining when equipment has become obsolete and must be replaced.

Similarly, it is a good idea to track health services publications. An inventory list that provides the publication name, author and publisher information, date of the publication and location of each publication, helps to provide accountability for state property and assists in reordering decisions.

Likewise, inventory lists are needed to track the deployment and utilization of bulk medical supplies. Such lists should be broken down by institution and include the type, volume and expiration date, if applicable, of all supplies. Inventories should be checked periodically to determine utilization patterns. In the absence of a good inventory system, it is virtually impossible to control purchasing and avoid stockpiling by unit health personnel. It is particularly important to track supplies with expiration dates (e.g., IV fluid packs, lab reagents, certain sterilized materials), since if they are not used within their specified time frames, they are no longer effective.

The waste factor in many institutions is staggering, particularly regarding medications, since virtually all preparations have expiration dates. A good inventory system for bulk pharmaceuticals that lists the type, volume and expiration dates of all preparations by institution is a key factor in reducing waste. Conducting periodic inventories can help to adjust ordering patterns that more accurately reflect the volume of use. Additionally, pharmaceutical inventories can be helpful in quality assurance activities to track overutilization of restricted medications or those subject to abuse.

5. Logs, Checklists and Inspection Forms

Health administrators also need to devise mechanisms to track compliance with specific policies and procedures. For example, if the DOC has a policy that requires monthly inspection of first aid kits, a checklist often is developed that lists the approved contents and provides space for the inspector to note his or her name, the date of inspection and the findings. Such checklists may be designed to verify compliance with other policies as well including safety checks of emergency equipment, the contents of the crash cart and/or emergency drug box, health environment inspections of the institution etc.

Other policies may require that sharp instruments and needles be counted at least weekly, control drugs be counted per shift, or that inmates in segregated status be visited daily by health personnel. Each of these policy requirements necessitates developing a log or some other mechanism for staff to document that they are complying with specific procedures.

Further, for administrative management purposes, other types of logs or information systems are needed to keep track of patients scheduled for

sick call, chronic clinics and specialty consultations, or those with appointments at outside health facilities.

6. Statistical Reports

For monitoring, budgeting and planning purposes, health administrators need a wealth of statistical information on health care activities and utilization patterns. The health care activities report should reflect the number of patients served monthly at each institution by each of the primary programs (i.e., medical, dental, mental health) as well as data from ancillary services (e.g., pharmacy, laboratory), special therapies (e.g., respiratory, physical, occupational) and support services (e.g., transportation, patient education, staff training). Within each of these major headings, further breakdowns by level of provider and specific activity or procedure enhance the utility of the statistical data.

Tracking the frequency of use of outside services is necessary as well. For example, an administrator may want to know how many patients had diagnostic procedures or specialty consultations by outside providers each month, the number of times emergency transportation was used and the type (e.g., ground, air), and the frequency of hospitalization.

For inpatient care (whether provided in the DOC's infirmaries or by outside hospitals), more extensive utilization data are helpful. The basic bed utilization information that may be collected includes total number of beds, total monthly admissions, total monthly discharges, average daily census, total number of patient days and average length of stay.

7. Patient-based Data

Finally, good data are required to address adequately the health needs of the inmate population. Chapter VIII on programming for special health needs emphasized the necessity of creating patient-based data systems to track the incidence and prevalence of specific diseases and the frequency of special conditions of inmates such as physical handicaps, advanced age, retardation or terminal illness. The absence of epidemiological information, morbidity and mortality data, and data on the frequency of special conditions makes it difficult to ensure that the health needs of existing inmates are being addressed appropriately and impossible to plan for future populations.

D. Data Collection and Management[11]

From the listings in the prior sections, it is easy to become overwhelmed by the data collection and documentation activities recommended to manage effectively a statewide correctional health system. Popular literature continues to stress that this is the information age. In comparison to previous eras, this is a distinction of degree rather than of kind, since all human activity has required information in order for decisions to be made. If this is the information age, it is only because information needs increasingly are recognized as critical for decision-making.

Fortunately, as the need for information has increased, so has the technology to process, manage and retrieve data. The ability to gather, manipulate and analyze data, and to translate data into information has been enhanced greatly by the development of sophisticated machines. The adding machine has been largely replaced by the calculator and then the computer, and the typewriter by the word processor. In the subsections that follow, some computer terms are defined, the advantages and disadvantages of using computers for data management are discussed, the structure of a management information system is described, and considerations in developing a database are presented.

This section does not discuss the technical aspects of computers in any detail. Its focus is on the development of databases, their use, and the kinds of activities that a computerized system can support. To a lesser extent, reference is made to computer systems and their relevance to specific applications in a health program. The underlying assumption is that an administrator or health specialist need not be an expert on computers. However, it is assumed that the majority of individuals reading this chapter appreciate and are reasonably comfortable in using the new technology.

1. Definition of Terms

The design and use of computers has spawned new terminology -- much of it jargon. Verbs have been created out of nouns (e.g., inputting and outputting), new acronyms devised (e.g., RAM, CRT) and as Thomas notes, commonly used English words have been assigned subtle differences in meaning.[12] An example of the latter is the use of the terms *data* and *information*. In ordinary speech, these two terms are used interchangeably. In the

language of computers, the term *data* refers to raw facts while the term *information* is reserved for when data are translated into knowledge by answering specific questions. Other terms used in this section are defined below.

Hardware -- The hardware is the physical equipment itself. Bharucha (1986) states that *hardware* encompasses anything you can see or touch including the electronics of the machine (e.g., central processing unit, memory chips) and all peripheral devices (e.g., monitor, disk drives, keyboard, printer, modem).

Software -- The software consists of the various programs that control a computer system. Each *program* can be thought of as a set of instructions that tells the computer's electronic system how data are to be processed and displayed. There are a plethora of software packages for processing many different types of data (e.g., word processing, accounting, databases).

Word Processing -- In essence, word processing is a software package that enables the computer to perform as a sophisticated typewriter. Documents can be entered into the computer in text form and stored for future reference. Word processing is most advantageous for documents that require periodic updating such as job descriptions and policy and procedure manuals, since it is not necessary to retype whole documents to reflect changes.

Management Information System (MIS) -- This term simply refers to an organized way of processing and analyzing data so that they can be used to yield information for operational and management purposes. It is worth noting that creating a management information system is not dependent upon a computer. In the absence of computers, manual information systems should be developed.[13]

Database -- A database is part of an overall MIS. There are any number of database software packages available for purchase. All of the pieces of data with respect to a single entity (e.g., a person, an institution) comprise the *record* and all of the records together in that database comprise a *file*. A DOC's health system might have several different databases (e.g., patient profiles, drug profiles, institutional delivery system profiles), which may or may not be linked to one another. Where the databases are linked in some fashion, this is known as a *relational database system*.

Spreadsheet -- A spreadsheet is a type of software that may be another part of an overall MIS. These software packages display data in rows and columns and are most useful in finance, budgeting, scheduling and forecasting activities, since they allow the user to develop "what if" scenarios. They are useful also in performing basic statistical analyses. A special feature of spreadsheets is that when one data element is changed, the software automatically reflects that change in all other designated categories.

Input -- Input refers to all of the data entered into the computer whether for word processing or MIS purposes.

Output -- Output refers to all of the data flowing out of the computer, whether sent to the computer monitor for viewing or generated into hard copy (paper) form.

Screen -- Bharucha (1986: 5) defines a screen as "the basic output device for visual display of a reserved area of memory."

On-line -- This term simply refers to data that are immediately available to the users of a given computer program as distinguished from data that may be stored externally from the computer system (e.g., archived or stored on diskettes or magnetic tape).

2. The Pros and Cons of a Computerized MIS

In this day and age, the advantages of using computers to manage data are clear to most people. For one thing, computers can organize data in ways that allow for convenient retrieval as well as multiple uses. When data are on-line, they are immediately

available to all who have access to that program. Also, it is easier to edit, update and append on computer disks than it is on hard copy. Further, computers can manipulate, calculate and analyze vast quantities of data much faster than traditional machines and store such data in relatively little space. Additionally, assuming that the input is accurate, computer output can be more reliable than manually processed data.

On the other hand, using computers to manage data has its own built-in concerns. Purchasing equipment (hardware) and designing programs to manage data (software) can be very expensive. While it is generally less costly to purchase existing software packages than to design them *de novo*, the tradeoff may be that the DOC has to tailor its information needs to the data capabilities of the software package. As discussed later, this is a backwards approach since information needs should dictate what data are collected and not *vice versa*.

Also, using computers can be very labor intensive in the set-up, training of users and data entry phases. Time involved in set-up is of less concern, since this is usually a one-time activity for any new computer system or program. Training, though, is a repetitive activity since each new staff member must be familiarized with the computer capabilities and operations, and all users must be updated periodically as software programs are added or changed. Data entry is the most time-consuming. In many systems, using computers involves an extra step since data are collected manually, recorded on a form and then entered into a computer. Even where the manual recording step is skipped and data are entered directly into the computer, there is often little time saved in data entry -- especially when clinicians' time is used to perform what is essentially a clerical function. Rather, it is the frequency with which data are accessed and the ease of retrieval that determine whether computerizing data will be more efficient in the long run.

Another concern associated with computers is the assumption that the output is always reliable. While it is true that computers do not make mistakes (unless they are malfunctioning), people do, and people are still responsible for computer programming, data collection and data entry. The reliability and validity of computer output are totally dependent on the reliability and validity of computer input. The phrase "garbage in, garbage out" has been coined to underscore this point.

A further problem with computerization that must be addressed is the danger in tying data into complex equipment that is subject to damage or breakdown. Good computer back-up systems are needed in the event that data are destroyed or the primary system malfunctions. Some software programs that are on-line (e.g., medication administration recording) necessitate developing a manual recording system as back up as well, so that the activity does not stop even when the computer is down. In these cases, data are recorded manually on a form compatible with the computer screen and entered into the computer when its functioning has been fully restored.

Finally, one of the more important considerations in using a computerized information system is that of controlling access to data and information. In a health system, this is particularly crucial for patient profile data, since the rules and regulations governing confidentiality are strict. While most computer programs provide for the use of passwords, codes or identification cards to restrict access, it is usually much easier to obtain a password than it is to gain entry into a locked medical records room or one guarded by the average health records practitioner.

In balancing the pros and cons of computerizing data, the decision usually comes down to which data should be computerized. Computers provide a clear advantage in word processing activities and in managing certain types of statistical data. Given the cost of data entry and storage, however, there is little advantage to computerizing data that are not retrieved frequently nor those that do not lend themselves readily to manipulation and analysis (e.g., narrative progress notes).

3. Structure of an MIS

It is not necessary for correctional health administrators to be experts in computer systems. Such expertise in MIS development is readily available from consultants or often elsewhere in the DOC. What is important is that correctional health administrators have a basic understanding of the structure of an MIS and its capabilities so that they can work with computer experts to design an MIS that meets their management information needs.

An automated data processing system (ADPS) consists of hardware, software and data. The hardware can be organized in a number of ways:

> Centralized system -- In this instance, the computer system includes a mainframe or central data storage and work stations at the local level. The ADPS can be

integrated totally so that it shares a common database and a standardized processing system.

Stand-alone system -- Such a system consists of separate microcomputers at the local level only, with no links to a mainframe system in the central office. This arrangement may be workable for a small correctional system, but might be counterproductive for a larger one where lots of data from all components of the DOC need to be stored.

Combination system -- This ADPS uses a central database and processor, with smaller processors at the local level. The latter can have their own database and also use the central processor. Microcomputers can be located at the local level, share the central common database, and concomitantly, have a database that has local applications.[14]

Today's technology in hardware and software development point to increasing use of combination systems with some level of integration; for example, a common database and standardized transactional processing. Microcomputers at the local level are linked with the central processor, with each other and with other units in prisons within the system. Software development makes it possible for a number of applications that can limit activities to the local level or that can send specific data to the central computer, while preserving confidentiality.

Examples of data categories amenable to transactional processing within a combination system that could use a standardized program include:

Prescriptions -- An inmate prescription could be entered into the computer at the local prison, entered into the database, and used for cost purposes, inventory control or quality assurance monitoring. If the inmate were transferred, the prescription could be called up by the receiving facility in order to provide continuity of medication.

Medical census data -- Information on the inmate population could be used for the DOC's inmate health profiles. It could be stored centrally and be available to both the local prisons and central office.

Financial data -- Budget expenditures at the local level could be stored either locally or centrally and shared by both.

Personnel data -- Vacancies, hires, etc. could be part of the common data pool.

Epidemiological data - Data on diseases at local prison units could be part of the common data pool as well.

Software with specific applications can be utilized in a combination system. Additionally, microcomputers with relatively large data storage capacity, which can be augmented with peripheral storage systems, provide flexibility that is not available in a centralized configuration.

It is not possible to provide a review of all the software applications that have been developed in the last few years that are available to health programs. A great number of applications have been designed for hospital use, and some of these are being modified or have the capability of modification for use by correctional health systems. Additionally, several DOCs including Arkansas, Florida, Iowa, Utah and Texas have computerized certain portions of their health services data collection activities and may be willing to share their knowledge and experience in software development and use.

One software development that should be noted is the relational database system. It can be used to generate portions of the health record including the physical examination, sick call visits, problem lists, diagnoses, prescriptions, diagnostic referrals, allergies, and other health-related data. Some of these programs allow specific data to be sent to a common database, and to be accessed by others, while restricting data entry to designated levels of health providers. For example, only the physician can enter diagnostic information, prescriptions and diagnostic referrals. Nursing staff can access the file to record physicians' orders, medication administration data etc. Any change in the record by physician or nursing staff is recorded with the name of the person making the new entry, but without erasing the prior entry. Selected data can be sent to the common data pool, but data cannot be entered into the record by anyone other than persons with authorization.

Through software, the relational database can be linked to an inmate tracking system so that inmate transfer data are available. This is useful in preparing inmate records for transfer, and in

developing summaries for inmates being transferred to other state systems.

Such software programs are often "user-friendly" in that they do not require learning complex key formulas. Instructions appear on the screen that specify which keys to press for specific entries. For example, patient allergies may be displayed automatically when the physician indicates that a prescription is to be entered. In other words, the program interacts with the user and the user's needs.

The usefulness of the relational database system is its simplicity and its flexibility. It can serve both the common data pool and local information needs. It provides data for management, monitoring and quality assurance purposes and helps to protect confidentiality by limiting access and controlling data entry.

Connecting the program to a printer provides hard copy for the health record as needed and allows individual pages to be printed when it is determined that the physician's signature is necessary.

4. Developing a Database

Developing information capability begins with the development of a database, which can be either manual or automated. In either case, limits must be set as to what data will be collected. All data collection and analysis activities have cost implications. The extent of time and labor needed varies with the method of collection (which is almost always manual), the method of retrieval (manual versus machine) and the method of storage. Since these activities are all costly, careful thought needs to go into database planning.

Database development should begin by addressing specific questions. The most important of these is to determine what information is needed. A health program is a complex operation and the pool of potential data is large. It serves no purpose to collect data that require much effort to maintain if the data are not used to provide answers to management questions. Gathering data to satisfy curiosity or on the basis that they might be needed "someday" is not good management practice. If data have no current identifiable use, they should not be included in the initial database. As more information needs are identified, existing databases can be amended or software programs can be added or new databases created.

Generally, data are needed that provide information on costs, utilization patterns, quality assurance activities, trends in diseases, population characteristics etc., because they will be used in forecasting, monitoring, planning or daily decision-making. There may be other underlying rationales for data generation, and if so, they need to be identified clearly.

In order to determine information needs, some generalized categories should be identified and the availability of data within those categories examined. For planning purposes, the following categories are suggested:

> Transactional processing -- This category includes daily activities such as inventory control, inmate transfers, billing or vouchering, and appointment scheduling. These categories are self-explanatory. They are the daily activities that are basically clerical and administrative.
>
> Operations management -- This category includes those activities that support the ongoing operation of the health program and may include aspects of the health record, frequency of sick call utilization, "no shows", diagnostic reports, chronic clinic schedules, prescriptions, in-service training schedules and attendance records, and quality assurance data.
>
> Management and planning -- Data need to be identified that will provide information for management decision-making, alert management to emerging problems and assist management in planning for future needs (for example, information that provides monitoring of the health program including cumulative pharmaceutical costs, hospitalization and diagnostic costs, staffing needs, epidemiological data, mortality data etc.).

Once information needs have been specified and data sources identified, some thought must be given to how the data will be analyzed and presented. It is customary to read annual reports of correctional agency activities that consist of page after page of categories and numbers representing activity levels by health units or the central office. The reports are replete with data, but result in no information. Such reports are seldom enlightening other than to inform the reader that a great deal of work has been done in the past year. They suffer from a format that defies

either comparative analysis or identification of trends.

The reader may glean some statistics about the health system, the kinds of care provided and perhaps cost, but there is no information or format to indicate what all of this means. The identification of data to be included in the database, therefore, must include a parallel effort in formulating, or at a minimum, defining how the information will be presented. Careful consideration should be given to the configuration of data so that they have maximum usefulness to all levels of management and operations.

Some examples of formatting or presenting information include the following:

Population profiles -- A profile of the population for the reporting year may be useful for facility planning purposes, but without information about the previous year's profile, it is not possible to identify trends in illnesses or physical conditions.

Epidemiology -- Current data without past figures for comparison are limiting. Knowing the number of TB cases or PPD conversions for the current year is not as helpful as showing changes from the previous year. Further, percent values alone may not be informative since, for example, an increase from one case to five may reflect a large percentage increase that is misleading.

Prescriptions -- Data presented may include categories of medications, number of prescriptions and total cost by category; however, gross costs should be accompanied by costs per facility and the previous year's costs. Increases and decreases should be noted and an attempt made to indicate reasons for such changes.

Quality Assurance -- Some quality assurance studies may use the database. For example, relating diagnostic categories to prescriptions is possible with a computerized database. Such a study might compare prescriber practices by facility, by provider or both. Such information provides management with an opportunity to monitor this activity.

With the framework of the database in place, attention should turn to identifying data collection techniques. Clear instructions must be provided to all individuals responsible for gathering data regarding what data are to be collected, who is to do it, when it is to be done and how often. Additionally, each data element must be operationally defined to ensure standardization. If this is not done, any reports generated from such data may be flawed. Even something simple such as "date" requires definition. Does that mean today's date? The date the data were gathered? The date the data were entered? A data dictionary should be developed for each data collection activity.

Finally, in computerized systems, whoever is responsible for setting up the database should provide a codebook that explains the abbreviations used for naming each data field and the responses within that field. Space requirements in many software packages restrict the number of characters that may be used to name a field or the number of characters allowed within that field for the range of responses. This forces the program set-up person to devise abbreviations and alpha or numeric codes that may be unintelligible to the uninitiated. For example, in a report using the field for ethnicity, *OTHASN* might lead the reader to believe that this was a little known minority group as opposed to an abbreviation for *other asian*. Failure to provide such a codebook limits the value of the database, since future users may ignore it because they cannot understand the variable names and the codes. Similar documentation of other aspects of program set-up is recommended.

The development of an information system is a conceptual effort. It does not require a great deal of technical expertise. What is important is to know what kinds of information are needed and the purpose for which data will be used. Usually, it is the software and not the hardware that is the primary consideration in the development of a computerized information system. The software can be problematic. Where possible, existing applications should be used since the development of tailor-made programs is expensive. Since numerous software packages have been developed or are in the process of development, it is necessary for the DOC's health staff to research these and determine which are appropriate for their needs. Generally, name brands and standard software packages provide the greatest flexibility.

E. Conclusions

In health care, the need for good documentation practices as well as information for management, planning and monitoring activities and services is or should be apparent. Prior to the wide use of computers, documents were typed and statistics on activities and budgeting were done, and in some cases are still done, manually. Today, many if not most correctional agencies have some automated data processing capability. The extent to which computers are used in the DOCs' health programs, though, is not known.

This chapter has examined some of the documentation and data needs of a correctional health system and suggested ways that computers might be helpful in word processing and data management activities. The "information age" has provided easier access to information, especially in data retrieval and data manipulation, but identifying, organizing, collecting and using data remain critical human efforts. At bottom, the purpose of improved documentation and data management is simply to better serve our patients.

ENDNOTES

1. See Lindenauer and Lichtenstein (1979: 8).
2. For more information, see NCCHC (1987: 3-4 and 54-59).
3. It should be clear that in the example given, deviating from the DOC's procedures generally would not violate the scope of permissible activities for an EMT.
4. See Dubler (1986: 100); and NCCHC (1987: 44). For more information about the POMR format, see Helbig and Ellis (1979).
5. See Gannon (1988: 31-38).
6. *Ibid.*, pp. 21-30 and Appendix C.
7. *Ibid.*, pp. 55-56.
8. AMRA (1985: 8) as cited in Gannon (1988: 56).
9. The model policy statement can be obtained from the American Medical Record Association, 875 North Michigan Avenue, Suite 1850, Chicago, IL 60611. (312) 787-2672. Alternatively, it is quoted *verbatim* in Gannon (1988: 59-61).
10. These recommendations are consistent with NCCHC's requirements (see NCCHC, 1987: 45).
11. I am indebted to Mr. Nick Pappas who provided an earlier draft of this section of the chapter from which I have borrowed liberally.
12. See Thomas (1979: 5).
13. The manual by Thomas (1979) provides a good overview of management information systems for the uninitiated. He discusses both manual and computer-based MIS structures.
14. See Davis (1974), Chapter 9.

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CHAPTER XII

IMPROVING THE QUALITY OF CORRECTIONAL HEALTH CARE

It may seem odd to some that the emphasis on the quality of care comes at the end of this book and not at the beginning. Many critics of correctional health care believe that it is the lack of quality care that has resulted in such extensive litigation against individual institutions and entire correctional systems. To a large extent, that is true, but it is also true that correctional health practitioners cannot deliver quality care in the absence of an infrastructure that supports the health delivery system.

How health services are organized within the DOC, the staffing levels and qualifications of staff, the types of care and services offered, the system for identifying and managing patients with special health needs, the emphasis on preventive health measures, the adequacy of the space devoted to health services, the existence of a policy and procedure manual, the development of a standardized unified health record, and the availability of good data for planning and decision-making all impact on the ability of correctional health practitioners to provide quality care. Problems in any of these areas can lead to poor outcomes in clinical matters. In fact, this chapter argues for a broader definition of improving the quality of correctional health care beyond traditional notions of quality assurance.

Section A defines some of the terms used in this chapter. Section B discusses the need for quality improvement programs and the purpose they serve. Section C looks at internal efforts to improve quality and distinguishes between traditional quality assurance programs and the more recent emphasis on continuous quality improvement. Section D describes external quality improvement programs that are available and compares the health care accreditation processes offered by the American Correctional Association, the Joint Commission on Accreditation of Healthcare Organizations and the National Commission on Correctional Health Care.

A. Definition of Terms

Quality assurance (QA) -- A process of ongoing monitoring and evaluation to assess the adequacy and appropriateness of the care provided and to institute corrective action as needed. In the past, QA focused solely on clinical performance, but has been expanded to include some organizationwide activities.

Utilization review (UR) -- A component of organizationwide QA that focuses on controlling the use of resources in a cost-effective manner while maintaining quality. A UR program looks at areas such as inappropriate inpatient admissions, length of stay considerations and the use of ancillary services. Overutilization, underutilization and inefficient scheduling of resources are examined in the review process.[1]

Risk management -- A program or process designed to protect the financial assets of an organization through assuring appropriate insurance coverage, reducing liability when an adverse event occurs, and preventing the occurrence of events that lead to increased liability.[2] Fromberg (1988: 132) notes that "[i]t is in this third area that the overlapping responsibilities of risk management and quality assurance programs become most evident."

Infection control -- An organizationwide QA effort designed to "prevent, identify, and control" both nosocomial infections (i.e., those originating in a hospital or infirmary) and those brought into the organization from the outside.[3]

Safety program -- An organizationwide effort tied to both QA and risk management that is designed to provide a safe environment for staff, patients and visitors by preventing accidents, injuries and other safety hazards.[4]

Credentialing -- A review process whereby the qualifications of health professionals (e.g., licensure, experience, training, certification) required for employment are verified and the extent of clinical privileges determined. Credentialing is done most appropriately at the pre-employment stage, but periodic reevaluation of health staff's credentials is necessary as well to ensure that qualifications are current and privileges extended to the professionals are valid.

Peer review -- An organized evaluation of professional competence performed by individuals in the same profession or discipline (i.e., one's peers). In health care, nurses review nurses, physicians review physicians etc.

Continuous quality improvement (CQI) -- CQI is a "...system for continual improvement of processes through design and redesign. The aim of QI is elimination of variations of defect, through elimination of causes to the variations. QI is proactive in nature: it seeks to build product and service quality into the design of the process."[5]

B. The Purpose of Quality Improvement

Why should DOCs be concerned about the quality of health care provided to inmates? If asked, many correctional administrators and health professionals would respond that the primary purpose of improving the quality of care is to reduce the potential for litigation and adverse judgements that can be extremely costly to the state. That may well be one result of improving quality, but it is not the primary purpose. In fact, in systems where traditional quality assurance programs are driven by concerns for reducing the DOC's potential liability, they can be only partially successful. Such programs breed fear and anxiety among health staff. Covering one's tracks becomes more important than the care provided and staff sometimes resort to lying in their documentation rather than to admit an act of omission or commission that was in error.

The primary objective of quality improvement efforts should not be to fix blame when things go wrong, but rather, to make systems work so that the "right things" are done right the first time. Improving the quality of care has its own intrinsic rewards, not the least of which is higher staff morale. An organization that emphasizes quality is able not only to attract but to retain qualified health professionals. Reducing turnover and "burn out" among the staff results in cost savings to the system. Additionally, while it may seem platitudinous to say that a happy staff is a productive one, just because something is trite does not make it untrue. W. Edwards Deming, the modern day "guru" of quality improvement in the private business sector, notes that "[c]ontinual reduction in mistakes, continual improvement of quality, mean lower and lower costs.... As costs go down, through less rework, fewer mistakes, less waste, your productivity goes up."[6]

In systems where the quest for quality is driven by litigation concerns, one of the almost inevitable consequences is an increase in the cost of care -- owing not just to providing a higher level of service, but also to providing care that is not needed. Practicing defensive medicine is not unique to corrections, of course. It has become a way of life for many clinicians in the community. Their fear of malpractice lawsuits leads them to order expensive diagnostic tests and procedures in order to rule out even the remote possibility of rare diseases and conditions. Such practices, coupled with the availability of advanced technology, contribute to the ever-spiraling costs of health care.

The relationship between quality and cost is somewhat paradoxical. A lack of quality increases costs. Improving quality reduces costs, but at the same time, there are costs associated with improving quality. Nackel and Collier (1989: 2) explain it this way:

> *Costs of improving quality include prevention and review. Costs of a lack of quality include failure. Prevention are those costs associated with actions taken to ensure that treatment failures do not occur. These include formal training costs, as well as on-the-job training and appropriate treatment planning. Review costs include such things as quality review and second opinion. Internal failure costs include rework required because of treatment failures, unnecessary work, review of work, and downtime associated with scheduling and staffing failures. External failure costs include such things as liability costs, rejected claims, PRO denials and lower collection rate and increased marketing costs due to poor quality.*
>
> *To summarize the cost-quality relationship...improving quality reduces costs, improves productivity and improves service levels.*

From the above discussion, the benefits of instituting quality improvement programs should be clear, but how they are conducted is important as well. Identifying gaps in the quality of care to fix blame is self-defeating. The focus should be on identifying problems to take corrective action as well as on preventing problems in the first place. Fromberg (1988: 65) states that corrective actions may address "...deficiencies in staff knowledge,

problems in behavior, or deficiencies in systems." He explains each of these areas more fully as follows:

> *To improve staff knowledge, actions may include modifying orienting procedures, providing focused in-service education, providing focused continuing education, or circulating written policies and procedures or other informational material.*
>
> *Addressing problems of behavior identified through monitoring and evaluation can be difficult. Appropriate actions may include:*
>
> - *informal counseling;*
> - *formal counseling;*
> - *changes in assignments; and*
> - *disciplinary sanctions.*
>
> *...Actions to improve systems may involve any of the following:*
>
> - *Changes in communication channels;*
> - *Use of consultant services;*
> - *Changes in organizational structure;*
> - *Establishment of new positions;*
> - *Changes in inventory;*
> - *Adjustments in staffing;*
> - *Revisions in job descriptions;*
> - *Added or revised policies and procedures; and*
> - *Changes in equipment.*

If a quality improvement program is designed with recognition that poor clinical outcomes may be the fault of something other than an individual clinician's performance, health staff are much more likely to participate willingly and even endorse such efforts. There are times, of course, when the responsibility for a poor clinical outcome rests with the provider. Even here, though, the system's response to such errors does not have to be punitive to the point of dismissal. Retraining a staff member in procedural matters, enrolling the individual in special continuing education offerings, or changing the person's job assignment may be other options, assuming a positive attitude on the part of the employee. What is important is that whatever is done be constructive. Dismissal is the least constructive option since it does nothing to solve the problem of poor care by a provider; it simply shifts the problem to a different health setting.

The activation of the National Practitioner Data Bank (NPDB) will make it more difficult for health care entities to palm off poor practitioners on another employer. The establishment of the NPDB was mandated by Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended by Public Law 100-177.[7] The scope of the NPDB's operation was expanded subsequently by Section 5 of Public Law 100-93, the *Medicare and Medicaid Patient and Program Protection Act of 1987*.[8] When opened, the Data Bank operated under the original Title IV provisions. Section 5 requirements were to be implemented later after the rules had been published.

Title IV Data Bank reporting requirements may be summarized as follows:

- All malpractice payments on behalf of <u>any</u> licensed health practitioner must be reported to the Data Bank and to appropriate state licensing boards.
- State licensing boards for physicians and dentists only must report any disciplinary actions taken against the licenses of these two professional group members.
- Hospitals and some other health care entities (e.g., HMOs, certain medical and dental group practices) must report adverse actions based on issues of professional competence or conduct that are taken against a physician's or dentist's clinical privileges which will last more than 30 days. Such actions must be based on formal peer review procedures.
- Medical and dental professional societies must report adverse actions taken against the membership of physicians or dentists when 1) that action was reached through a formal peer review process and 2) it was based on the practitioner's competence or conduct.[9]

Regulations specifically state that reporting requirements are not retroactive, but rather, start

from the date the Data Bank became operational, which was September 1, 1990.[10]

The purpose of the *Health Care Quality Improvement Act of 1986*, which mandated establishing the National Practitioner Data Bank, has been described as follows:

> *The Act itself is intended to further two important goals: 1) improving the quality of medical care by encouraging physicians and dentists to identify, for disciplinary purposes, other physicians and dentists who engage in unprofessional behavior; and 2) restricting the ability of incompetent physicians and dentists to move from state to state without disclosure or discovery of previous damaging or incompetent performance. The Data Bank is intended to facilitate the second goal by developing a central repository for information related to professional conduct or competence.*[11]

The applicability of NPDB reporting requirements to corrections has not been established. Mindy Reiser, PhD, Education Manager of the National Practitioner Data Bank, stated that inquiries from DOC staff regarding applicability are being turned over to NPDB's legal counsel for a ruling on eligibility.[12] Eligibility of the health care entities that are required to report seems to turn on the existence of a formal professional review process that provides due process safeguards for the practitioners being reviewed. The irony is that health care entities without formal peer review programs may well be those with the highest number of practitioners with substandard performance or unprofessional conduct.

To some, it may seem that the way to avoid the reporting requirements of the NPDB is not to establish formal peer review mechanisms, but this is a short-sighted approach. As stated previously, implementing quality improvement programs has substantial benefits for an organization. If the focus of quality improvement is broadened beyond traditional quality assurance and peer review programs, then such efforts may well benefit individual practitioners. In other words, the recognition that poor clinical outcomes may be the result of factors other than poor performance on the part of practitioners may lead to a decrease in the number of adverse actions taken against individuals. Further, organizational efforts to work with practitioners to help them improve their performance is a much more positive approach than the practice of dismissing individuals without reporting them. The latter serves only to shift the problem and not to solve it.

In sum, the goals of a quality improvement program and the reporting requirements of the NPDB need not be incompatible. The latter can be viewed as a "last resort" measure in quality improvement efforts.

C. Internal Programs to Improve Quality

Every DOC should establish its own internal mechanisms to improve the quality of the care it offers. In the subsections below, traditional quality assurance efforts are described and contrasted with the newer emphasis on continuous quality improvement.

1. Quality Assurance

Quality assurance (QA) activities generally consist of monitoring and evaluating the patient care provided as well as aspects of other programs such as utilization review, risk management, infection control, safety programs, peer review and credentialing. The QA model used most often in community health care facilities is that of the JCAHO. The discussion below identifies the key components of JCAHO's quality assurance model. Appendix K contains an example of a policy and procedure from the Illinois system that applies the JCAHO model to a correctional health setting.

a. Developing the QA Plan

Initiation of a quality assurance program should start with the development of a written QA plan that specifies "...the program's objectives, organization and scope as well as the mechanisms used to oversee the effectiveness of individual quality assurance activities."[13] Within a DOC, each institution should have its own QA plan. Additionally, there should be a plan for the DOC as a whole that coordinates the institutional plans, specifies reporting requirements and identifies systemwide QA activities.

b. Formulating QA Objectives

Objectives of the QA programs need to be formulated. The DOC's staff can generate its own objectives or adopt those from other QA programs.

QA objectives have been defined elsewhere as follows:

- *To assure all patients receive appropriate and timely services in a safe environment.*
- *To assure systematic monitoring of the treatment environment.*
- *To assist in reduction of professional and general liability risks.*
- *To enhance efficient utilization of resources.*
- *To assist in credential review and privilege delineation.*
- *To enhance identification of continuing education needs.*
- *To facilitate identification of strengths, weaknesses and opportunities for improvement.*
- *To facilitate coordination and integration of information systems.*
- *To assure resolution of identified problems.*[14]

c. Defining the Scope of QA Activities

Specifying the objectives of the QA program helps to define the scope of QA activities. From the objectives listed above, the scope of the QA program would encompass medical staff monitoring and evaluation (including completeness of the medical record, timeliness of care and appropriateness of care), and aspects of safety, infection control, risk management, utilization review, credentialing, peer review and the adequacy of data collection processes. Further, the above objectives imply that all departments/disciplines/services involved in health care delivery will be part of the QA process.

d. Specifying the QA Process

Under JCAHO's model, a ten-step monitoring and evaluation process has been designed for use in all QA activities. The same process is applicable for medical staff QA activities (e.g., departmental review, drug usage evaluation, medical record review, pharmacy and therapeutics function); for clinical services QA activities (e.g., nursing, laboratory, pharmacy, emergency); and for organizationwide QA activities (e.g., infection control, risk management, utilization review, safety). According to JCAHO's manual:

> *The ten-step process for monitoring, evaluation, and problem solving is designed to help an organization effectively use its resources to manage the quality of care it provides. The process involves ongoing* monitoring *of care provided, periodic* evaluation *of care,* identification *of deficiencies in that care, and* improvement, *as necessary, of the quality of care. The individuals or groups responsible for various steps of monitoring and evaluation, the reporting processes, and the methods of integrating information will vary in different organizations. Of overriding importance is that*
>
> - *monitoring and evaluation activities are ongoing, planned, systematic, and comprehensive;*
> - *data collection and evaluation are adequate to identify problems; and*
> - *actions taken to solve problems are effective.* (Fromberg, 1988: 49)

Each of the ten steps is described briefly below.[15]

1) *Assign responsibility*

Decisions must be made regarding who is responsible for specific QA activities. The statewide QA plan should specify who is responsible for quality assurance at the central office and at each prison in the system. Each of these individuals, in turn, must assign personnel to complete various QA activities.

2) *Delineate the scope of care*

Each department/discipline/service involved in health delivery should list the activities it performs. For example, the transportation section might begin its list as follows:

Responsible for:

- maintenance of all health services vehicles,
- inspecting and maintaining all supplies and equipment on health services vehicles,
- scheduling drivers,
- training drivers in procedures and safety measures,

- coordinating transportation with appointment scheduling department,
- transporting patients to their appointments in a safe and timely fashion,
- and so forth.

This list should be as detailed as possible.

3) *Identify important aspects of care*

From the list created in step two, each department/discipline/service needs to identify those activities that are the most crucial in terms of potential problems, frequency or risk. Typically, high volume activities or those that have created problems in the past or those that have the greatest potential for serious negative outcomes are designated "important aspects of care." The important aspects of care in each area become the focus for monitoring and evaluating activities.

4) *Identify indicators*

For each of the important aspects of care identified in step three, indicators of quality should be identified. JCAHO defines an indicator as "a defined, measurable variable relating to the structure, process or outcome of an important aspect of care for which data are collected in the monitoring process."[16] *Structure* relates to supplies, equipment, personnel and other physical resources. For the transportation section, a structural indicator might be "All drivers have a current chauffeur's license." *Process* refers to the procedures used to carry out a specific activity. "Vehicle inspections are conducted monthly" is an example of a process indicator. *Outcome* relates to the results of particular activities. Accident rates and the rate of appointment rescheduling owing to transportation problems are examples of outcome indicators.

Each indicator may have more than one *criterion* of measurement. For the process indicator above, specific criteria might be developed regarding who conducted the inspections, the scope of the inspections, the completeness of the documentation etc., in addition to measuring whether the inspections were timely.

5) *Establish thresholds for evaluation*

JCAHO defines a threshold as "a level or point at which the results of data collection in monitoring and evaluation trigger intensive evaluation of a particular important aspect of care to determine whether an actual problem or opportunity for improvement exists."[17] Each indicator should have a threshold set that prompts a more in-depth review when it is reached. A threshold can be thought of as a tolerance level for error or variability. Certain indicators may be so important that the threshold is set at 100% compliance (or zero tolerance for variability). For example, thresholds for indicators of staff licensure may be set at 100%. For other indicators, it may not be realistic to set thresholds at 100% (e.g., zero tolerance for wound infections), because perfection is not possible. For still other indicators, the importance of the activity does not justify an absolute standard. In the transportation example, the threshold for transporting patients to their appointments in a timely fashion might be set at 95%, recognizing that bad weather or unexpected traffic tie-ups or occasional equipment failures could delay patients five percent of the time and still not indicate a systemic problem.

6) *Collect and organize data*[18]

Once the indicators have been defined and the thresholds set, staff need to collect data for each indicator. The source of the data will vary depending on the indicator. Licensure data may be found in personnel files or a computerized MIS. The primary source for clinical data is the health record. Transportation logs, inspection records and appointment schedules may yield data for transportation indicators. For each QA study, it also is necessary to specify the sample size (i.e., the number or percentage of incidents, cases or records to be reviewed), how the sample is to be selected (e.g., random, stratified), the time parameters that define the sample (e.g., cases occurring over the past year, incidents arising over the next six months), who is to do the data collection and how it is to be done. The format of the data collection instrument for a particular QA study should allow for periodic tabulation of results.

7) *Evaluate care*

When cumulative data reach the established threshold (or fail to reach it depending on how the indicator and threshold are phrased), this signals the existence of a potential problem. Data should be analyzed to determine whether trends or patterns exist. Sometimes, problems can be traced to specific days or shifts, or to specific providers, or to specific categories of patients (e.g., those in segregation) or even to individual patients. Other times, there is no discernible pattern, but a problem still is apparent from the cases reviewed. When data analysis reveals that the problem might rest with particular providers, the information is given to the appropriate peer review committee, which then investigates the matter further.

8) *Take action to solve problems*

Evaluating the data in step seven should provide some indication of the potential source(s) of the problem, which leads to an action plan to resolve the problem or increase the extent of compliance to an acceptable threshold. Common causes of problems often fall into three categories:

a) insufficient staff knowledge (which can be improved by clarifying policy and procedure statements, changing or instituting in-service training programs or conducting continuing education programs);

b) system defects (which can be corrected by improving processes, equipment or materials; or by altering organizational structures, job descriptions or communication lines; or by changing staffing ratios and levels or operational procedures); and

c) individual staff members' attitude, performance or behavior (which can be addressed by counseling, changing job assignments, restricting privileges or dismissal).[19]

9) *Assess actions and document improvement*

The QA study does not stop with the implementation of an action plan. The monitoring and evaluation process continues to determine whether the corrective action resulted in any improvement in the problem. The action plan might specify that an ongoing QA activity continue for the next six months to determine the efficacy of the solution implemented. If no or little improvement is demonstrated, the problem is reassessed and a new action plan devised, implemented and evaluated. If the action plan successfully addresses the problem, a decision must be made as to whether the problem is likely to stay solved for a period of time or is likely to recur with some frequency.

In the former case, the decision might be that the QA study would be terminated and reinstituted at some later date. This may well be the decision with respect to system defect problems, which should not continuously repeat themselves once the system has been "fixed." For example, if a QA study determined that the primary cause of delay in getting patients to their appointments in a timely fashion was owing to an unacceptable level of vehicle breakdowns, and the action plan resolved to improve the preventive maintenance of vehicles and/or purchase new ones, and the assessment of the action plan revealed that it had been successful in resolving the problem, the decision might be to cease ongoing evaluation and monitoring of this aspect of care and reinstitute a QA study only periodically. On the other hand, certain aspects of care must be continuously monitored. Problems attributable to insufficient knowledge of staff, or to performance or behavior of individuals may well recur owing to changes in staffing and in the staff themselves. Continuous QA studies often are conducted on high volume, high risk or problem-prone issues to ensure that an appropriate level of quality is maintained.

10) *Communicate information to the QA program*

The last step in JCAHO's process is to determine who is to receive what information from which QA studies. The lines of communication should be specified in the DOC's systemwide QA plan and will vary with the organizational structure selected for the QA program. Possible organizational arrangements are described below. In reporting the results of QA studies, care should be

taken to ensure that the confidentiality of patients' medical information is not breached and that providers' identities are protected. This can be done by aggregating the data or using codes.

e. Determining the Organizational Arrangement

The responsibility for the quality assurance program might rest with a single individual (e.g., the medical director or a QA coordinator), with a central quality assurance department, with a multidisciplinary QA committee, or with a series of separate QA committees organized along departmental lines. In a large DOC, the possible arrangements become more complex and are likely to involve several different combinations of individuals for specific QA activities. To a large extent, the way health services are organized and structured within the DOC[20] will dictate the organizational arrangement for the QA program. JCAHO offers several different organizational models that could be adapted to a correctional setting.[21]

In general, the DOC's central office should have a designated individual, department or committee that is responsible for developing the systemwide QA activities, training unit staff in the QA process, coordinating QA activities at both the unit and central office level, conducting systemwide QA studies, overseeing organizationwide QA activities (e.g., safety, risk management, peer review) and summarizing reports from unit QA studies to be used in action planning for the system as a whole. To maintain the integrity of the QA process, central office QA staff should report directly to the statewide health services director.

At the unit level, the simplest and most effective arrangement is usually to establish a multidisciplinary QA committee that meets regularly (at least quarterly) to decide what studies should be done, to establish indicators and thresholds, to review the results of ongoing studies, and to decide on action plans for correcting identified problems. The core committee should consist of representatives from major health programs and services (e.g., medical, dental, mental health, nursing, pharmacy). Representatives from ancillary and support services should be added to the QA committee on an *ad hoc* basis depending on the nature of the QA study being conducted. In 1991, JCAHO required each department/discipline/service involved in health care delivery to continuously monitor at least two indicators. Larger services (e.g., nursing) may have several ongoing QA studies and some QA studies may cut across department organizational lines (e.g., the adequacy of sick call services for segregated inmates).

It also is a good idea to include a representative of the custody administration staff on the core QA committee. Some of the identified problems in the quality of health care and services are likely to be related to system defects in custody matters. Alternatively, custody staff's observations and input may identify problems in health services that should be reviewed by the QA committee. This does not mean that the custody representative should gather data on clinical issues or participate in peer review activities. There is no breach of confidentiality, though, if s/he listens to results of QA studies that are reported in the aggregate or helps to decide which areas of health service activities should be studied.

f. Assessing the Effectiveness of the QA Program

Finally, JCAHO requires an annual appraisal of the QA program. Fromberg (1988: 45) states that this should include:

- *assessment of the monitoring and evaluation process to determine its effectiveness;*
- *comparison of the written plan with the quality assurance activities that were performed;*
- *determination of whether quality assurance information was communicated accurately and to the appropriate persons, committees, or other groups; and*
- *determination of whether identified problems were resolved and patient care improved.*

Such an appraisal will help to determine whether any revisions are needed in the written QA plan. Annual appraisals of QA activities should be conducted by each institution's QA committee and by the individual or group responsible for the systemwide QA plan.

2. Continuous Quality Improvement

Continuous quality improvement (CQI) is the latest term applied to certain efforts to measure quality. CQI -- also called quality control or total quality control, quality management or total quality management -- has its roots in the concept of statistical control of variability. Its primary proponent, W. Edwards Deming, is an American, but the Japanese were the first to embrace CQI as a way to improve their productivity after World War II.[22]

Deming's philosophy of continuous quality improvement is quite simple. His observations of management practices in private industry led him to believe that traditional notions of quality control were misplaced. Many American businesses relied on inspections at the end of the assembly line to control the quality of their products. Workers were paid on the basis of piecework or the fulfillment of quotas. Everything was judged on the acceptability of the final product. Deming believed that inspection at the end of the line was inappropriate. In his words:

> *Inspection with the aim of finding the bad ones and throwing them out is too late, ineffective, costly.... In the first place, you can't find the bad ones, not all of them. Second, it costs too much.... Quality comes not from inspection but from improvement of the process. The old way: Inspect bad quality out. The new way: Build good quality in.*[23]

Deming recognized that there were a number of factors along the way that could account for variability in the end product. For example, the raw materials themselves could be of poor quality, or some of the equipment could be faulty, or some of the workers could be poorly trained, or the procedures could be inefficient etc. If inspection is left to the end, it is too hard to determine where in the process the defect occurred. In Deming's view, the right way to approach quality is not to put out fires through after-the-fact inspections, but to prevent fires through continuous quality improvement at every stage of production.[24]

Deming's management method has been distilled into what he calls the Fourteen Points (principles of CQI that should be implemented), the Seven Deadly Diseases (which should be avoided), and the Obstacles (which need to be overcome).[25] It is not relevant to review all of them here, but there are a few that have particular applicability to corrections. Two of Deming's points relate to the need for instituting a formal system of training and retraining. Traditionally, corrections has relied more on "on-the-job training" (OJT) for its personnel than it has on formal training by skilled educators. Deming insists that OJT is the wrong approach, since it perpetuates the replication by new personnel of errors the untrained trainer may be making. Some of what staff learn through OJT may be right, but a lot of it may be wrong. In Deming's view, continuous formal training is required until the worker's performance in a particular job is in statistical control.[26]

Three more of Deming's points relate to staff relationships.[27] He believes that the role of a supervisor is to lead, not to order people around; that people must feel secure in their jobs, because an atmosphere of fear is counterproductive; and that the barriers between staff areas must be broken down, because competition between areas can result in conflicting goals that hamper efficiency and effectiveness. Implementation of such concepts in corrections would be revolutionary, since traditionally, corrections has operated on the basis of power, hierarchy and "turf building."

Deming's final point relates to taking action to accomplish the transformation from a system of quality through inspection to one of continuous quality improvement, which relies partially on each worker satisfying his/her customers.[28] In Deming's view, a *customer* is anyone who receives a worker's product and therefore, customers can include both individuals internal to the organization as well as those external to it. Under this philosophy, a correctional health professional's customers would include supervisors, co-workers, custody staff and inmates as well as the public at large.

The Deming management method was adopted readily by the Japanese, but largely ignored in America until the 1980's when some of the larger manufacturing concerns such as the Ford Motor Company, American Telephone and Telegraph and the Campbell Soup Company began to utilize some of his techniques.[29] Application of CQI to the health field has been even more recent and is now stressed by JCAHO.

It is important to recognize that the emphasis on formal objective assessment of the quality of health care is only about two to two and a half decades old.[30] Roberts and Schyve (1990: 9) state that JCAHO's movement from QA to CQI "...is not conversion to a new religion nor does our interest

reflect adoption of the latest fad." Rather, they argue that CQI is the next step in the evolution of quality in the health care field, which started with peer review, moved to retrospective medical audits, and then to systematic quality assurance programs.

In fact, the differences between QA and QI are more in degree than in kind. JCAHO's quality assurance process described in the prior section already encompasses many of the principles of CQI. The primary difference is in how QA has been carried out traditionally.

Roberts and Schyve note that the weaknesses of quality assurance include the following:

- *QA is largely driven by external requirements....*
- *QA is focused primarily on clinical care....*
- *QA activities follow organizational structure, not the flow of patient care....*
- *QA focuses on individuals, not processes....*
- *Quality "assurance" holds out unrealistic expectations of perfection....*
- *QA does not foster integrated analysis of efficiency and effectiveness....*
- *QA activities often do not support the professional instinct for self-assessment and constant improvement* (1990: 10-11).

They argue further that the principles inherent in CQI will address the flaws in QA, but that remains to be seen. It also is not known how well management techniques borrowed from industry and applied to health care will fit in the alien environment of corrections. Corrections, after all, is not a business in the same sense as a manufacturing plant or even a hospital. The ultimate consumers (i.e., the inmates) of corrections' "products" are unwilling "buyers" who cannot go elsewhere if they are dissatisfied. On the other hand, corrections does have external customers such as legislators, the public and the courts that it must satisfy, but unfortunately, they are not all of one mind regarding the quality of the "product" corrections should offer. Further, CQI relies on notions of quality for quality's sake, which results in capturing a bigger share of the market, not on quality driven by external requirements where the industry itself has no control over its "market share."

Additionally, applying CQI techniques to the health services component of a DOC may not be easy. Some of the organizational barriers to implementing CQI in corrections were noted previously. It seems unlikely that a correctional health division would be able to implement a total CQI approach successfully unless the DOC as a whole adopted that philosophy. Like it or not, health services is just one component of a correctional system and cannot operate independently from the DOC as a whole. Budgeting practices, training requirements, personnel policies, certain operating procedures and the organizational structure of correctional health services often are not under the direct control of health professionals.

When all is said and done, though, perhaps it is less important which quality improvement method a DOC adopts for its health services than it is that one is adopted. Staff in many correctional health systems are just now starting to grapple with internal quality improvement mechanisms. They need to learn more about available techniques and see what works in their unique environment. Efforts to improve quality do have their own rewards in reduced costs, improved productivity and higher staff morale. Deming is right that the search to define and maintain quality should be continuous.

D. External Programs To Improve Quality

In addition to internal quality improvement programs, it is useful to have the DOC's health services reviewed periodically by external groups. Internal assessments can determine the extent to which the DOC's health services staff are complying with its own policies and standards of care, but they often do not reveal gaps or deficiencies in the DOC's policies and standards themselves. Operational standards, clinical practices and definitions of quality are not absolute. Evaluation by an outside body can bring a fresh perspective on the adequacy of the DOC's health delivery system and the care provided. Periodic review by state medical societies, public health departments, state licensing boards and consultant experts can be of great assistance in improving certain aspects of a health delivery system. The most comprehensive external evaluations, though, are those offered by national accrediting organizations.

There are three such national bodies that accredit health services in corrections: the American Correctional Association, the Joint Commission on Accreditation of Healthcare Organizations and the National Commission on Correctional Health Care. Differences in the standards used by these three organizations were summarized previously.[31] Differences in their accreditation processes are discussed below.

The format of the steps leading to accreditation is pretty much the same for all three accrediting bodies.[32] Accreditation is initiated when a representative of an agency completes an application that provides some basic data about his/her facility. Such information is used by the accrediting bodies to establish fee schedules, identify contact persons and obtain an overview of the facility's size, services and personnel.

Next, facility personnel are encouraged to complete a self-assessment tool. Both ACA and NCCHC require submission of the self-survey document to their respective organizations, but JCAHO does not. All three accrediting bodies offer pre-survey consultation and technical assistance upon request.

The next step in the process is the on-site survey. All three organizations send a team of surveyors to the facility to measure compliance with their standards. The composition of these teams and the activities they undertake on-site does differ as discussed later.

At the conclusion of the on-site survey, team members review their findings with designated representatives of the facility. A written report is completed by the survey team and submitted to staff at the accrediting agency. The report is presented to an accreditation committee, which makes the final decision on the facility's accreditation status. Full accreditation is awarded for three years by all three organizations. Each has its own rules and requirements for facilities that receive decisions short of full accreditation, but all three provide for some process of appeal.

The primary differences in the accreditation offered by these three groups are associated with conducting the on-site survey and with the fees charged for accreditation. Since ACA's accreditation is not focused on health services, its process provides the least comprehensive health review. The ACA's intent is to assess all aspects of the operation and management of a correctional facility, of which health services is just a part. As a consequence, its survey team (called a visiting committee) is composed of correctional experts, but seldom includes a representative of the health professions. This means that ACA's auditors can determine whether policies and procedures, health records forms and other documentation exist in the health service section, but generally are not qualified to determine the adequacy of the documentation or of the care provided. Additionally, ACA's process is less formalized in that its "...Visiting Committee reports its findings on the same Standards Compliance Checklist used by the agency in preparing its Self-evaluation Report."[33]

JCAHO's on-site survey teams are comprised entirely of health professionals, but not those with experience in correctional settings. It has a formal system of review that includes a complex standardized scoring system to determine the facility's extent of compliance.[34] JCAHO's approach provides an in-depth assessment of certain aspects of health care delivery, but its standards ignore those areas unique to corrections.[35] JCAHO's on-site survey process is limited further in that it has relied almost solely on documentation as the source for assessing the extent of compliance with its standards. Patients generally are not interviewed unless they formally request to meet with the survey team.

NCCHC's accreditation process offers the most balanced approach. It is more intense than ACA's accreditation in that NCCHC's is devoted solely to health care issues (as is JCAHO's), the on-site survey team includes correctional health professionals, and a formal set of survey instruments has been devised to measure compliance with standards that goes well beyond the checklist format used by ACA, but is not as complex as the scoring system used by JCAHO. Further, while NCCHC's on-site process does not review certain programs such as quality assurance or environmental health as intensely as JCAHO's survey does, the scope of NCCHC's on-site survey is more comprehensive with respect to correctional health issues. Not only are all traditional health services activities included in NCCHC's assessment, but so are those aspects unique to corrections including custody/medical interface, training of correctional staff in health-related areas, ethical matters affecting correctional health professionals etc.

Additionally, NCCHC's surveyors rely not only on the existence of documentation to measure compliance with standards, but also on structured observations and interviews. The latter are conducted with facility administrators (correctional and medical), custody staff (corrections officers,

training coordinators, food service directors), health professionals (at least one from each service area or activity and in some cases, several of the same type), and inmates who are the consumers of the health care delivered in corrections. In fact, NCCHC's on-site survey process is more like CQI and JCAHO's is more like traditional QA. The latter tends to concentrate on clinical care issues whereas the former looks at policies, processes, protocols, procedures and people that can impact on the quality of the care provided.

Finally, of the three, NCCHC's is the least expensive.[36] In 1990, for a prison with an average daily population of 500 inmates,[37] NCCHC charged $2950 for the initial accreditation survey and $1500 per year thereafter, including the years when reaccreditation surveys are scheduled to be conducted, for a six year total of $10,450. For the same size facility in 1990, ACA charged $7975 for the initial accreditation survey and $7770 for the reaccreditation survey for a six year total of $15,745.[38] JCAHO's fee schedule is more complicated. During 1990, its base fee for accreditation of ambulatory care facilities was $3750 plus $0.50 for the first 1,859 visits, plus $0.18 for the next 1140 visits, plus $0.064 for each visit over 3,000 per year.[39] It would not be unusual for a prison of 500 to average 1500 medical encounters per month by physicians, nurses and PA/NPs, not counting visits to other health professionals such as dentists and mental health personnel. Also, JCAHO charges additional fees for reviewing anything other than basic medical ambulatory care such as mental health services or infirmary care. Reaccreditation fees are assessed using the same schedule. Thus, while it is difficult to draw exact cost comparisons, JCAHO's accreditation process is generally the most expensive of the three.

The decision as to which accreditation a DOC's health system should seek depends on which will serve the needs of the DOC better. NCCHC's and JCAHO's accreditation processes provide a much more comprehensive review of health services than ACA's, and, because they are conducted by health professionals, are better able to withstand challenge. This does not mean that ACA's accreditation is not worthwhile. Where administrators of a DOC or an individual prison are interested in a comprehensive review of their total operations, they would do well to seek ACA accreditation and accreditation of their health services by NCCHC or JCAHO. Where an assessment of health services alone is required, accreditation by NCCHC or JCAHO is the better option.

E. Conclusions

Since the 1970s, the focus of most efforts to improve correctional health care -- whether by the courts, by national health organizations or by DOCs themselves -- has been on establishing an adequate delivery system. The time is now ripe for the emphasis to shift to improving the quality of care provided by correctional facilities. Staff at each DOC should develop internal mechanisms to define and measure the quality of the services offered.

Additionally, periodic review by outside groups, especially national accrediting bodies with standardized assessment processes, can help determine whether the DOC's health system is keeping pace with the larger health care community. The standards that define "quality health care" are not static, but continuously evolving. Similarly, providing quality care to inmates is not so much a goal to be attained as it is a process of continuous improvement of structure, procedures, policies and people.

ENDNOTES

1. Fromberg (1988: 128-129).
2. *Ibid.*, p. 132.
3. *Ibid.*, p. 126. See also the section on infection control in Chapter IX.
4. *Ibid.*, pp. 129-131. See also the section on environmental health and safety in Chapter IX.
5. Cassidy (1990: 7).
6. As cited in Walton (1986: 26).
7. Cited from the National Practitioner Data Bank fact sheet dated 2/9/90.
8. *Ibid.*
9. *Ibid.*
10. Personal communication, March 22, 1991 with Mindy C. Reiser, PhD, Education Manager, National Practitioner Data Bank.
11. Briefing (1990: 8).
12. Personal communication, March 22, 1991. Individuals who wish to know more about the Data Bank and stay current on reporting requirements can call the Data Bank help line at 1-800-767-6732 or write as follows:

    National Practitioner Data Bank
    8301 Greensboro Drive, #1100
    McLean, VA 22102

13. Fromberg (1988: 44).
14. From the National Association of Private Psychiatric Hospitals as cited in Cassidy (1990: 6).
15. More complete discussion of the JCAHO's ten-step process for monitoring and evaluation is found in Fromberg (1988: 49-72).
16. Fromberg (1988: 147).
17. *Ibid.*, p. 148.
18. For more information on data collection and management, see Chapter XI.
19. See Fromberg (1988: 65).
20. See Chapter V on organizational models and Appendix B for sample organizational charts.
21. See Fromberg (1988: 39-44).
22. Walton's book (1986) provides a good overview of Deming's philosophy on quality improvement as well as biographical data. See also Deming (1986).
23. As cited in Walton (1986: 60).
24. See Walton (1986) and Deming (1986).
25. *Ibid.*
26. See Walton (1986: 68-69, 84-85).
27. *Ibid.*, pp. 70-75.
28. *Ibid.*, pp. 86-88.
29. In her books, Walton (1986) and (1990) provides some case studies of the application of Deming's technique in various American enterprises.
30. See Roberts and Schyve (1990: 12).
31. See Chapter VII and Appendix E. The fourth organization with standards applicable to correctional health care (i.e., APHA) does not offer an accreditation program.
32. See ACA (1990: vii-xv); JCAHO (1990a: x-xx, 75-87); and NCCHC (1987: vi-vii) and (1990: 2-9).
33. ACA (1990: xiii).
34. See JCAHO (1990b).
35. See the standards' comparison chart in Appendix E.
36. It should be recognized that the fees cited were those in effect in 1990 and are subject to change. Interested individuals should contact the respective accrediting organizations for current pricing schedules.
37. These fees apply only to prisons. NCCHC's fees for reviewing jails and juvenile confinement facilities are even lower.
38. ACA (1990: viii). This fee is for the entire accreditation process, not just the health portion.
39. Telephone interview with Lance Hoxie, JCAHO's director of ambulatory care accreditation, on March 25, 1991 by Robert Burmeister, PhD.

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CHAPTER XIII

COST CONSIDERATIONS: FINANCING, BUDGETING AND FISCAL MANAGEMENT

No book on prison health issues would be complete without some attention paid to cost considerations of the care provided, particularly at a time when escalating costs of health care are coupled with unprecedented prison population growth. Financing, budgeting and fiscal management of correctional health care require intelligent direction and careful attention. In moderate to large systems, the assistance and involvement of persons with professional qualifications in this area is highly recommended.

This chapter reviews various cost issues associated with correctional health care. For those not well-experienced in this area, the discussion is intended to alleviate some of the fear and trepidation that the fiscal arena can cause for the uninitiated. It also offers some advice on where to start, what to consider, how to request funding, how to improve efficiency and how to control costs. Section A describes the financing options that are available to fund correctional health programs. Section B is devoted to budgeting issues and includes advice on developing a budget as well as what to do when funding is insufficient. Section C examines the cost of inmate health care in the various states whereas Section D addresses cost control strategies.

A. Financing

Financing options for correctional health services are limited. Potential sources of funding for programs include federal government sources, private sources, payments from prisoners and appropriations from the state legislature. The viability of each of these options is discussed below.

1. Federal Government Sources

As far as can be determined, Medicare and Medicaid payments are not generally available to state prisoners.[1] Medicaid may be available for eligible recipients in some states during the month in which they become inmates of a public institution, but even so, these dollars would represent only a small portion of a state's overall cost of care.

Some federal grants may be available from time to time, but typically for demonstration or research projects and not for ongoing operating expenses. In 1990-91, the issues of drug abuse and AIDS were hot topics, and some systems were able to obtain federal dollars from the National Institute of Drug Abuse (NIDA), the Centers for Disease Control (CDC) or other federal agencies to fund programs in these areas.

Further, some dollars may be available from the National Institute of Corrections (NIC) to fund technical assistance requests on correctional health topics. Additionally, some training money is usually available, especially to subsidize attendance of correctional health staff at NIC's National Academy of Corrections' programs.[2]

Eligible veterans can receive certain care at no cost in veterans' facilities. In some instances, this care is limited to treatment of service-related illness or disability. Rules and policies as well as their interpretation may vary widely, but it may be worth checking -- making inquiries and perhaps carefully following a test case or two. The state Veterans' Administration representative can be a helpful resource. If the path opens up, then it may be worth adding a question or two for all incoming prisoners about their veteran status and eligibility, noting this information prominently on the face of the health record for use in the event of future major medical costs.

In the main, though, the federal government is not a likely source of funding for ongoing correctional health programs. The halcyon days of easy access to federal dollars for correctional programs are over and are not likely to come again.

2. Private Sources

Do not overlook the possibility of a grant from a foundation or private beneficiary or from a professional organization, drug company etc. for research and development or for continuing education. Again, however, the availability of private dollars to fund state correctional programs has

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This chapter was developed by B. Jaye Anno and Kenneth L. Faiver.

decreased in recent years and never was widely available to fund operational programs.

Private insurance is another possible source of dollars to pay for some inmates' health services, but most health insurance contracts exclude coverage of prisoners. When they do not, this avenue should be considered, e.g., for new arrivals who were covered through employment and may be covered to the end of the current month (although often the person has not worked for many months and thus, coverage would have lapsed) or is under the age limit of the parents' policy (e.g., 18 or 22) or is covered by the policy of an employed spouse or has coverage from a prior injury on the job or an automobile accident. These policies, if available, can be of great benefit when major medical expenses are incurred and should be utilized where possible.

3. Prisoners Pay for Own Care

From time to time, it is suggested that prisoners pay for their own health care -- if not the whole amount, at least some co-payment so as to deter unnecessary utilization of services. It is argued that since the prisoner experiences no out-of-pocket costs, s/he has no incentive to avoid overutilizing or abusing the services that are offered.

Establishment of a co-payment system also may be viewed as a means of generating revenue, but fees high enough to generate appreciable revenues will inordinately reduce utilization. Moreover, the cost of collecting the co-payments is not insignificant and might well exceed any revenue generated. Therefore, the only possible economic benefit would result from decreased utilization. A reduction in access to services for individuals who need them is sure to invite litigation, which is often more costly than providing the care in the first place. Legal issues associated with co-payment in a prison setting have not been tested. Some lawyers suggest that these payments may be unconstitutional, if they can be shown to discourage basic access to necessary health care.

Another problem with this proposed remedy to "malingering" and overuse of sick call is that it fosters the creation of a two-tier system favoring the "affluent", while the indigent prisoner receives less care. Even a 10-cent or 25-cent co-payment fee is "major" in the prison economy; certainly $5 or $10 per encounter would be prohibitive for inmates in most systems.

It is a well-known fact, in the community as well as in prisons, that a small minority of persons consumes the vast majority of health services. These are generally persons with *bona fide* acute, chronic or terminal illnesses. Any co-payment system would have to include special provisions to minimize adverse impact on this group.

There is a better solution than co-payment. It begins with ensuring full and unimpeded access to the primary level of the prison's health care delivery system. Here the prisoner typically encounters a nurse, or possibly a psychologist, social worker or other clinically trained person who listens to the complaint and evaluates the extent of need. Once the prisoner has "entered" the delivery system, all referrals to more specialized and more costly levels of care should be the decision of professional staff based on an objective assessment. In this way, the relatively few persons who choose to abuse sick call regularly will not impose significant monetary costs on the system, while legitimate users will have ready access to all appropriate levels of care.

4. Legislative Appropriations

The vast majority (if not all) of operating funds for corrections come from state legislative appropriations. Hence, it is necessary for the statewide health services director to understand something about how this process works. Typically, a funding request is initiated within the agency itself and, after obtaining approval of the director, is passed to the office of management and budget (OMB) which reviews, and often modifies or even rejects, the request on behalf of the governor. From there, the budget request is sent to one of the houses of the legislature, usually to a committee on appropriations, possibly to a subcommittee for corrections. The legislative committee may have the request analyzed by a fiscal agency. Budget hearings usually are held separately by the house and the senate. Differences between the two houses are reconciled by a conference committee. Finally, the appropriations bill is acted on by the entire legislature and is presented to the governor for signature. Along the way, numerous pitfalls and deviations lie in wait. An appropriations request may languish and die in committee. It may be rejected or it may be vetoed by the governor.

It is advisable that the statewide health services director (HSD) be permitted to meet directly with the staff from fiscal agencies (of the governor or OMB) and the legislature to explain needs and programs and to answer questions. Also, the HSD should be present at significant budget hearings in

legislative appropriations committees to answer questions directly or to explain new programs. Rarely can this be done as effectively by non-medically trained intermediaries. Such persons tend to misunderstand or only partially grasp important program details and priorities and only poorly represent them or unfortunately, concede points that should not be conceded, or "trade" without realizing or fully appreciating the value of what was traded, during a negotiating session.

Careful preparation for budget presentations is essential as is careful preparation of the budget itself.

B. Budgeting

1. Definition and Uses

A *budget* is a plan for allocating resources. All resources are "scarce" in the sense that when more is spent for one purpose, less of that resource remains available for other uses. This is true whether an individual is dealing with his/her own personal financial resources or with an appropriation of tens of millions of dollars for correctional health care. In fact, preparing and managing the budget must be counted among the basic functions of a correctional health care administrator.

A health services director will find at least three important uses for a budget: seeking funds for a program, planning program expenditures, and monitoring and controlling expenditures.

a. Seeking Funds

An agency describes its program to a funding source (e.g., the legislature) and presents a list of funding needs and an accompanying rationale. If the request is sound, is adequately defended and is accepted -- possibly with some modifications -- funds are made available to the user agency.

b. Planning Expenditures.

The decision to spend resources should not be made haphazardly, but according to a plan that is designed carefully to achieve a desired objective and to do so efficiently without waste.

c. Monitoring and Controlling Expenditures.

Once a program is underway, ongoing efforts are needed to ensure that the resources are spent according to plan. Mid-course adjustments may be required and the budget then serves both as a guide and as a limiting factor.

2. Approaching the Budget Process

Before proceeding further with the budgeting process, some time and effort should be devoted to clarifying the mission of the agency. While at first, this may seem obvious and unnecessary, careful preparation and discussion of a "mission statement" will help to refine and focus the understanding of exactly what the program aims to accomplish.

A conceptually sound approach to the budgeting process, once the mission has been made clear, includes these steps: first, determine mission; second, define (determine) patient needs; third, specify the services required to meet these needs; and fourth, identify the resources necessary to provide these services.[3]

All too often, the process is employed in reverse. Someone starts with the available resources and proceeds to determine what services these resources can produce or purchase, ultimately arriving at a definition of the patient needs that can be met with these resources. The problem is that unmet needs may not be recognized. Each step of the process requires some attention.

a. Defining Patient Needs

"Patient need" may be expressed quite generally. Is it a dental care program? Is it inpatient care? Prenatal care? Physical therapy and rehabilitation? Primary outpatient care? Geriatric and disabled care? A detoxification program? How large is the population of need? How does this population tend to differ from some other population whose needs are better known? How much illness is expected in the population? How else may one estimate the character and magnitude of need?

b. Specifying Services

"Services" must be defined more closely. What particular bundle of services will be adequate to address these needs? For example: hours per week of nurse-attended sick call, hours per week of physician-attended clinics, number of inpatient beds (at what levels), hours of counseling (by what type of professional) etc.? To the extent that data are available or it seems to be useful, these broad

categories can be specified further into discrete meaningful categories.

c. Identifying Resources

The kind and amount of resources required flow logically from the bundle of services to be produced with the resources. The illustration in Figure 1 shows what the operation of a certain clinic for one year might require.

In specifying the resources that will be employed, the program manager needs to define the appropriate production function -- in other words, what method (what set of inputs) will be used to produce and deliver the service and what combination of resources will be required? The optimum choice will depend both on what the technology requires and on the price of each factor of production. For instance, some services can be produced legally only by a licensed physician. Yet a physician plus a nurse may be able to see twice as many patients (assume in this case that they legally, and without diminished quality, produce twice as many equivalent services) as the single physician working alone. If the cost of a physician and a nurse is only 70 percent of the cost of two physicians (who, by definition, could perform the equivalent amount of services), the former combination is more efficient. What if one physician, two nurses and one clerk could produce the same quantity (and quality) of work, but would cost only 60 percent as much as three physicians? Then, the former would be an even more efficient combination of resources as long as this quantity of services were needed. Otherwise, there would be excessive and costly unused capacity. As another example, the purchase and use of a computer might permit the introduction of a technologically more efficient outpatient scheduling system.

A similar kind of decision compares the efficiency of "make" versus "buy", or "produce" versus "contract." For example, should the prison have its own pharmacy or is it better to contract out for pharmacy services? Should it operate its own ambulances or purchase ambulance services? These are volume-dependent decisions, but also hinge on a number of other factors.[4]

The goal here is to select technically efficient and price efficient solutions. Technical efficiency means that the medical services will be produced using the minimum number of inputs of any given proportion. Several different combinations of inputs, however, may be technically efficient. To minimize the cost of providing services, the decision-maker must choose among these several technically efficient combinations to determine which combination is also economically efficient. This is done by considering the relative costs or prices of the different inputs as well as their productivities.[5]

The efficient solution may not be identical at all locations. At a large central prison, for example, a major pharmacy operation (open 16 hours per day and seven days per week with several pharmacists and aides) may be quite appropriate. At a smaller rural facility, contract pharmacy services with a local drug store could be the best approach. Similarly, a small facility located near the central prison might be served more efficiently through courier arrangements with the main pharmacy.

The cost per unit of service can be kept relatively low at institutions with larger prison populations, while at smaller institutions, a disproportionately higher cost must be incurred owing to the need to maintain a given level of administrative overhead. For example, one clinic administrator can run a large unit consisting of both inpatient and outpatient functions, while at a smaller facility, that one administrator may have only an outpatient clinic.[6]

Keep in mind, however, a significant scale size factor unique to the prison setting. The larger the prison, the more difficult and risky it becomes to maintain security. Higher population levels tend to be less manageable. Conversely, lower population levels may be more costly per unit in the health care function, but less risky for security purposes.

One additional point should be emphasized in the identification of needed resources. A program may have "hidden costs" which, when explicitly identified and properly estimated, can alter the outcome of a cost-benefit analysis and result in a different management strategy. Examples include costs of custody, transportation, personnel office services, business office services, staff recruitment and training costs, and other administrative overhead. These components can be safely ignored only where they are minor.

3. Some Terms and Distinctions

Some clarification of frequently encountered terms may be helpful:

Fixed v. Variable Costs. In any operation, some costs remain the same in the short run,[7] no matter how much of the service is

Figure XIII-1

Sample Formula for Specifying Resources

P physicians at an average cost of p dollars per physician
N nurses at an average cost of n dollars per nurse
C clerical staff at an average cost of c dollars per employee
E units of equipment at an average cost of e dollars per unit
S units of supplies at an average cost of s dollars per unit

Then, $P(p) + N(n) + C(c) + E(e) + S(s)$ = TOTAL COSTS

e.g.,	2 physicians @ $90,000 =	$180,000
	4 nurses @ $35,000 =	140,000
	2 clerical staff @ $18,000 =	36,000
	3 pieces of equipment @ $2,000 =	6,000
	1 piece of equipment @ $18,000 =	18,000
	4000 supplies @ [average] $5 =	20,000
	TOTAL	$400,000[8]

Figure XIII-2

Full versus Partial Fifty Percent Phase-In

	Full Year Cost	Full 50 Percent Phase-In	Partial 50 Percent Phase-In
2 physicians	$180,000	$90,000	$90,000
4 nurses	140,000	70,000	70,000
2 clerical staff	36,000	18,000	18,000
3 pieces of equipment	6,000	3,000	6,000
1 piece of equipment	18,000	9,000	18,000
4000 supplies	20,000	10,000	10,000
Total	$400,000	$200,000	$212,000

produced, while other costs vary according to utilization. As an example, staff already on the payroll require salaries whether they are busy or not. This is a fixed cost, though in the long run it, too, is variable since the staffing complement may be increased or reduced. However, some other costs, such as contractual employees, medications, consumable supplies, off-site hospital days or radiology fees, will vary according to usage.

The fact that costs are variable is an obvious concept, but variable with respect to what? And by how much? By way of example, numerous factors may affect the volume of medications dispensed, including the prisoner population level, variation in the case mix, provider prescription patterns or the number and types of provider staff. An in-depth analysis of the causal relationships among so many independent variables as they act on the dependent variable (in this case medications dispensed) is no simple task; yet to defend his/her budget effectively, the clinic administrator must attain such an understanding. Multiple regression or other sophisticated analytical techniques may be found useful.

Capital Outlay v. Operating Costs. This distinction is analogous to "one-time" costs and "ongoing" costs. Often, these costs are carefully distinguished in the budget. For the purpose of making projections to future periods, this is an important consideration. The cost of constructing a building or of purchasing an x-ray machine or a dental chair will not be repeated each year while staff salaries, supplies and utilities are operating costs and are ongoing or recurring.

Encumbered v. Expended. In calculating a year-end expenditure projection, the manager must take into account not only the amount of funds already spent (expenditures), but also the amount that has been committed to be spent (encumbrances) during the current fiscal period, even though the payment transaction may be incomplete. Sizeable encumbrances can significantly affect a budget projection. For example, one may know that the hospital bills for several patients currently in off-site medical/surgical facilities will, upon discharge, cost between $150,000 and $200,000. If this is not taken into account, the year-end expenditures could be underestimated by this amount.

Line-Item Budget. This is a plan that identifies proposed spending without identifying the specific projects on which the money will be spent.[9] Instead, costs are summarized based on the character of the expenditure. For example, a total salary amount of $356,000 for the medical program does not distinguish the costs of physician coverage for the inpatient unit from the salaries of the clerical staff in the outpatient clinic or the nursing staff etc.

This is the most commonly utilized form of budgeting within state agencies. Its advantage is its flexibility, but its drawback for the clinic administrator is the difficulty of accurately determining after the fact how much was charged to each subprogram within the overall heading of "Medical Program." Costs tend to be rolled up into summarized reports, with little detail for the administrator to scrutinize and control.

Personnel v. "CSS&M". These are the commonly employed aggregations of operating cost categories. *Personnel* is a combination of salaries and wages, holiday and overtime pay, as well as fringe benefits including retirement, insurance, social security and longevity payments. *CSS&M,* an abbreviation for "contractual services, supplies and materials," can be construed as covering "everything else," such as travel, supplies, contracts, utilities, fees and sometimes equipment.

Phase-in. This is a strategy in which the funding authority provides a portion of the funding during the first budget year. Subsequent cycles then include the balance of the program. This practice allows the legislative funding authority to buy into a new program without having to commit the full level of approved resources immediately. For example, a full 50 percent

phase-in of the zero-based budget example noted earlier (see section B.2.c.) would yield a funding level of $200,000 in year one, although if only the personnel and consumable supplies were to be phased in, the result would be $212,000, as illustrated in Figure 2.

The rationale for phase-in funding is, in part, a recognition that most new programs need time for the necessary staff to be hired, for policies and procedures to be written, equipment to be obtained, and the physical plant to be built before the program can be put into full operation. In this respect, the administrator needs to assess carefully his/her start-up capabilities and requirements when submitting a request for funding.

Many of the terms noted above are relative, e.g., fixed or variable over what term? Some personnel are salaried, but others are contractual and the status of the same individual may change over time. What is the fine distinction between supplies and equipment? Is it cost or consumability? Typically, the state agency will have adopted a set of administrative rules that provide operational definitions for these terms.

4. Specifying Line Items

The final budget will contain a number of *line items* or funding categories specified in greater or lesser detail. At one useful level of aggregation, it might look something like the chart shown as Exhibit XIII-A. In most systems, staff will account for the majority of dollar costs in a budget -- perhaps 65 to 85 percent. Therefore, this portion needs to be developed with special care.

Usually, the funding source will determine a set of line items for the budget appropriation. However, this does not prevent disaggregation of the budget into additional discrete categories wherever this is useful to the manager.

In developing a budget -- as in any form of planning -- a cardinal rule is to make all assumptions explicit. Then, when modifications are made, the result is more understandable. Also, it is easier to defend a budget when the details are clear and well-documented.

5. Centralized versus Decentralized Budget Preparation

Each institutional health authority, as well as each mid-level manager over a discrete program area, can propose (and justify) his/her own budget and submit it to the statewide health services director (HSD) for review and approval. Alternatively, the HSD may draft a generic budget and send it to the institutional health administrators or program managers, who in turn, justify departures in either direction from this base. Whether budgeting ought to be centralized or decentralized is not really the important question. The process should occur at both levels. The initiative -- i.e., the first round -- can be either local or central, but there must be subsequent rounds, usually more than one. Therefore, it is of paramount importance that the cycle begin far enough in advance of the new fiscal year to allow careful consideration of all relevant issues.

6. Options When Funding Is Insufficient

To assist in control of expenditures, the budget needs to be broken out into monthly or quarterly periods. These should reflect, insofar as can be predicted, actual spending patterns rather than simply a division of the whole by 12 months or by four quarters as the case may be. Hiring of new staff, for example, often will be spread over some period of time and funds for this purpose may be phased into the spending plan so that a closer match is obtained. Monitoring of actual expenditures and matching them against the budget for the month (and year-to-date) enables timely mid-course adjustments when this becomes necessary. Available adjustments are of several kinds including reducing expenditures, shifting resources among line items or requesting additional resources.

a. Reducing Expenditures

A reduction in expenditures can be achieved in various ways, all of which should be considered:

1) Eliminate waste or improve the method of production and thus, be more efficient technically;

2) Use employee time more efficiently by creative scheduling of services;

EXHIBIT XIII-A
Sample Line Item Budget Format by Program by Institution

	INSTITUTIONS			
	A	B	C	D
PROGRAM	$	$	$	$
ADMINISTRATION				
Staff				
Equipment				
Supplies				
Contractual				
Travel				
Other				
MEDICAL				
Staff				
Equipment				
Supplies				
Contractual				
Travel				
Other				
MENTAL HEALTH				
Staff				
Equipment				
Supplies				
Contractual				
Travel				
Other				
DENTAL				
Staff				
Equipment				
Supplies				
Contractual				
Travel				
Other				
INPATIENT SERVICES				
Staff				
Equipment				
Supplies				
Contractual				
Travel				
Other				
ANCILLARY SERVICES (pharmacy, x-ray, laboratory, diet, physical therapy etc.)				
Staff				
Equipment				
Supplies				
Contractual				
Travel				
Other				
OFF-SITE SERVICES				
Contractual				
Travel				
Other				

3) Find less costly substitutes, e.g., employ some pharmacy technicians instead of all pharmacists, or renegotiate contracts for better prices;

4) Defer postponable services to the next fiscal period;

5) Reduce services by prioritizing need; and/or

6) Cut programs.

Note that "reduce quality" was not listed as one of the options since in most contexts, this would not be acceptable. In any case, this suggests the importance of mounting a good quality assurance and risk management program along with a budget/financial information/utilization data system. These can provide the manager with an "early warning" of quality deterioration occasioned by program contraction as well as with solid data to use in arguing the case for increased appropriations.

A reduction in costs does not necessarily mean a reduction in quality. Care can be wasteful of resources and costlier than it needs to be when it is produced inefficiently -- such as when physicians do the work of nurses or nurses the work of aides,[10] or when poor scheduling practices result in idle hours for paid staff. But when it is determined that reducing services beyond a certain point would mean sacrificing an acceptable level of quality, deleting the service entirely should be considered. Sometimes necessary services can be eliminated at one or more locations, provided prisoners who need the deleted service are transferred to a location where it is available. This decision will need to be made in consultation with custody administration. Often, however, the consolidation of certain services to fewer locations can result in significant economies without diminishing quality or access. Also, generally it is better not to claim to provide a service if it can be provided only poorly.

b. Shifting Resources

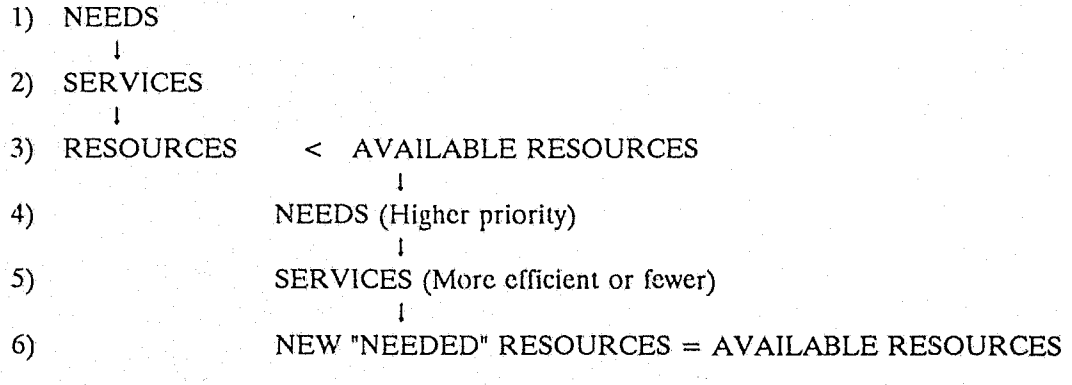
Earlier, it was recommended that budgeting proceed as follows:

NEEDS → SERVICES → RESOURCES

What if needs are found to exceed available resources? This can happen during initial budget planning if, for example, a target limit has been determined already by the legislature or governor. Or, it may be encountered when the OMB or the legislature rejects the budget proposal and assigns a lower level of funding. It also may occur at mid-year, either because the original estimates were wrong or because conditions unexpectedly changed, e.g., owing to population increases, price increases or a major hospital bill (especially a problem in a small system or at the institutional level where a single extraordinary expense cannot be actuarially covered). Or, it may be encountered when the legislature or governor or director assigns a budget cut -- e.g., five percent across the board -- after the fiscal year has begun.

When this happens, the recommended approach is still as described earlier, but proceeds in an iterative fashion making repeated adjustments and comparisons until equality is reached between projections of needed and available resources, as illustrated in Figure 3.

Figure XIII-3



Since available resources are less than the needed resources (Figure 3, line 3), the needs are scrutinized more closely and lower priority needs may be eliminated (Figure 3, line 4). Or, the delivery system is reviewed to identify areas in which services may be produced more efficiently (Figure 3, line 5). In either case, the process continues until the newly defined "needed" resources equal what is available (Figure 3, line 6).

c. Requesting Additional Dollars

An alternative solution may be reached by renegotiating the funding level based on clearly demonstrated need. Or there may be a conscious decision -- with knowledge and concurrence of the agency head -- to "go into the red", requiring some process of year-end funding transfer to cover the deficit, whether within the agency or from outside with legislative approval.

The health services director needs to know how much flexibility s/he has been given to modify the approved budget (spending plan) for a given institution or across program categories. This flexibility is dependent on a number of factors including who controls the budget and what legislative (or regulatory or policy) restrictions exist.

Systems differ, and the principles or approaches described here may not be allowed in some areas or under some circumstances. Therefore, the HSD should find out what is acceptable. Get sound and competent advice. Stay within accepted policy. If not sure, consult the agency head.

One practical suggestion is to request that the legislature fund a contingency account. By appropriating some of the dollars to such an account, the health services director can be allowed to authorize limited movement of funds across line items, permitting an over-expenditure at Institution A, but knowing it will be compensated by unexpended funding at Institution B. This approach is most useful for payment of major medical costs such as very large hospital bills. It allows sharing unpredictable incidence of extraordinary costs across a larger actuarial base -- i.e., across the statewide health care budget. Budgeting is not an exact science. It is an estimate whose actualization generally is subject to some factors beyond the manager's control. Therefore, some kind of limited flexibility is desirable.

There is also a well-known perverse incentive at work in the budgeting process of most state agencies. Operating funds rarely can be carried over to the next fiscal period. Transfers and supplemental appropriations are lengthy and uncertain procedures. While underspending usually leads to a reduction in subsequent appropriations, overspending can lead to funding increases. When this is a reflection of true differences in need, these actions are appropriate; but if the agency that ended the fiscal period with a surplus was highly efficient and the other agency that overspent its allocation was wasteful, the net result is to reward inefficiency and the old adage is verified: "No good deed shall go unpunished."

Therefore, a manager should carefully scrutinize overspending to look for signs of inefficiency and use excess funds to improve service capacity, when possible, within the unit or program area that demonstrated efficient management -- e.g., to buy a computer, to replace some obsolete or inadequate equipment, or to enhance a quality assurance program.

All of this reinforces the need for good management information and financial information systems.[11] The more that is known about expenditure and utilization patterns, about the rationale for cross-institutional differences, and the sooner it is known, the better it can be addressed effectively (either by directly controlling it or by persuading the funding source to grant additional resources).

7. Updating a Budget

Note that budgeting need not be a traumatic or major all-out effort (though it may seem so the first time or two). Once a good system is "up and running," the process should be maintained through periodic (at least quarterly, if not monthly) review of progress during the current fiscal year as well as at the time of any significant program revision. Each year (or biennially in some states), marginal revisions to the budget are in order, taking into account the program revision plans that have been developed. These include program changes, technical adjustments, economic adjustments and population adjustments as noted below.

> Program changes: e.g., add physical therapy program (staff, equipment, supplies). Add computerized patient scheduling system (equipment, software, staff, training etc.).
>
> Technical adjustments: e.g., change registered nurse position to licensed practical nurse position. Change pharmacist position

to pharmacy technician position. Move program and staff from one unit to another.

Economic adjustments: e.g., annual salary adjustment, promotions and step increases, price of medications or hospital contracts.

Population adjustments: In some places, population adjustments may be relevant, e.g., some funding may be allocated on a *per capita* basis.

8. Beyond Budgeting

A cost-effective manager requires more than a budget. Three related tools that furnish essential management information are:

Financial Management Information System (FMIS). A means of promptly retrieving a summation of expenditures (and encumbrances) by relevant category, month-by-month and year-to-date.

Utilization Data System (UDS). A means of promptly retrieving a summation of services provided by relevant category, month-to-month and year-to-date.

Unit-Cost Report System (UCRS). A marriage of the FMIS with the UDS, whereby the manager promptly receives a month-by-month and year-to-date report of expenditures per unit of service in all relevant categories.

Note the repetition and importance of the words "promptly" and "relevant categories." It will do the manager little good to learn how well or how poorly the operation was proceeding in the distant past. The information needs to be recent if it is to be useful. Likewise, careful forethought and planning must go into the definition of meaningful categories for aggregation and reporting of data. Some compromises may be necessary, since the program will serve multiple users, each with particular needs.

A fourth tool is a *quality assurance/risk management system (QA/RM)*, which is defined as follows:

> An ongoing, institution-based review of care delivery by professional peers, comparing findings with predetermined standards of care and identifying factors that increase risk and liability. There is a central office role to ensure adequate performance of the QA/RM mechanism and to provide periodic central (and external) review.[12]

It is well to conceive of these four systems, along with the budget process, as a package, because they are interrelated and each depends upon and supports the others. They do not need to mesh perfectly. As will be seen, some cost items are more sensitive than others and more amenable to control by the manager.

Often, past experience can serve as a guide and starting point. Cross-institutional comparisons of resources, services and costs can be useful also. These need to be adjusted for the size of the population served and for special considerations, e.g., a central prison where more sophisticated levels of inpatient and specialty care are offered will have a higher *per capita* cost than a prison camp where only healthy and "work-ready" inmates are assigned. Cross-comparisons among similar facilities should be very enlightening; hence the need to develop unit cost data by program element for each location in the system. This entails a blending of institution-specific service utilization data and cost data, e.g., total cost per prisoner, cost per prescription, cost of x-ray per x-ray procedure[13] etc.

Anecdotal, impressionistic or impassioned pleas for increased funds usually are not the most successful approaches -- certainly not on a consistent basis for the long run. Political alliances sometimes are suggested as the best way to get a budget approved. However, a sound, rational, cogent presentation, based on careful and documented analysis of data and trends, is the most effective approach in this area and the one most likely to succeed even when political support is lacking.

Sometimes, there are court orders that mandate improvements in the health care delivery system. Especially when these are quite specific, they can be very helpful in providing needed leverage. Even here, though, legislators and fiscal analysts rightfully may demand a cost-effective means for producing the required improvements.

How much justification should be attached to a budget request depends on how well the program is understood and appreciated by the funding source, whether it is a new program (or major improvement) and how tight are the fiscal constraints. "More" is not necessarily "better." What is presented should be

clear and succinct. "Budgeting by adjectives" usually does not work very well.

C. The Cost Of Care[14]

The cost of health services in the United States has escalated dramatically in recent years. At a congressional hearing in December 1989, a health policy expert testified that:

> *...U.S. health care spending exceeds $600 billion/year and is rising faster than the Consumer Price Index (CPI). The reasons include: increases in physician and other professional services; increased service intensity; new technologies; inflation; and population growth and aging.*[15]

Similarly, one would expect that the cost of providing health care to the nation's prisoners would have escalated for all of the reasons cited above as well as the added factor of litigation, which has forced a number of state correctional systems to increase their health care spending. But how much have these costs increased? A partial answer can be found by comparing the results of a survey undertaken by NCCHC in 1990 with results from similar published surveys.

In the spring of 1990, the National Commission on Correctional Health Care undertook a survey of the 50 state correctional systems and the Federal Bureau of Prisons (FBP) to determine how much each was spending on health services for prisoners. Usable responses were obtained from 46 states[16] and the FBP.

NCCHC's cost survey included questions regarding the fiscal period reported on, the total expenditure for the DOC during that period, the total expenditure for health services operations excluding new construction costs, a list of the program areas included in the health services cost totals, and the average daily number of inmates in the system for the year in question.

Every attempt was made to ensure that the data reported were comparable across the systems. Responses to the mail-out questionnaire were supplemented with telephone inquiries whenever questions arose as to the inclusion or exclusion of specific cost items. In all instances, the figures reported include mental health services as well as medical and dental care. Where mental health services were provided by a different section of the DOC or by an outside agency with a separate budget, adjustments were made to the appropriate cost figure (e.g., the total health expenditure figure or both the total health expenditure and the total DOC expenditure figures). Similarly, adjustments were made for non-agency hospitalization costs if these were not included in the totals reported.

In spite of these efforts, care should be taken in the interpretation of the cost survey results. Without conducting a detailed comparison of the line items included in both the DOCs' total expenditure figures and their total health services expenditure figures, it is impossible to determine the extent to which the cost data are comparable. For example, it is not known what the jurisdictions may have included in their total DOC expenditure figures. It is assumed that this figure represents all costs for each DOC for the period reported, but if new construction costs were included in some states but not others, or if the extent of new construction differed dramatically among the states, that could account for at least a portion of the difference in the amount expended per inmate on an annual basis.

The total expended for health services should be a better figure, because here at least, the informants were asked specifically to exclude new construction costs and to include mental health costs even if the latter service was provided by a different section of the DOC or an outside agency. Further, an attempt was made to identify the types of costs included in the health figures reported. As shown in Table XIII-2, health care staffing was included in all of the figures reported and other "big ticket" items such as hospitalization, specialty care, equipment and pharmaceuticals were included in virtually all instances. The only areas of substantive variability were in the renovation/repair and overhead columns, neither of which is likely to be responsible for much distortion in the averages. However, no attempt was made to control for differences in the cost of living among the states, so some of the variation in health care expenditures may be attributable simply to differences in the cost of care.

The time frame for which cost data were reported also differed to some extent (see Table L-1 in Appendix L). While most of the states[17] (N=34) reported cost data for the same fiscal period of 7/1/88-6/30/89, Texas reported for fiscal year (FY) 9/1/88-8/31/89, three states reported for the fiscal period 10/1/88-9/30/89, New York for FY 4/1/89-3/31/90, and eight states reported for their fiscal year of 7/1/89-6/30/90. Thus, the time frame varied by as much as a year.

While the data within states are less problematic since the base and the time period are the same, the data among states are subject to all the *caveats* noted above. With this in mind, the survey results are presented below. Table XIII-1 summarizes the results alphabetically by state whereas tables presenting the results on specific variables in rank order (highest to lowest) by state can be found in Appendix L.

Total DOC expenditures for the 47 jurisdictions reporting ranged from a low of $12 million in Maine to a high of almost $1.6 billion in California with the mean DOC expenditure totaling almost $258 million. The median expenditure for the 47 jurisdictions was $158 million (see Table L-2, Appendix L). Said another way, California's DOC was spending an average of about $21,000 per inmate per year whereas Maine was spending only about half that much ($10,041).

The total expenditures for health care ranged from a low of just over one million in South Dakota to almost $150 million in California with a mean total expenditure of about $25 million per state (see Table XIII-1) and a median of a little over $10 million (see Table L-3 in Appendix L).

The percent of the total DOCs' expenditures devoted to health ranged from a low of 2.8% in South Dakota to a high of 18.9% in Texas. The mean percentage expended on health was 9.5% (see Table XIII-1) whereas the median was 8% (see Table L-4, Appendix L).

The annual health cost per inmate varied significantly. South Dakota spent an average of only $787 per inmate per year on health services whereas Alaska spent over four times that much ($3381) annually per inmate on its health services (see Table XIII-1). The average expenditure per inmate per year across the 47 jurisdictions reporting was $1906 while the median expenditure was $1665 (see Table L-5, Appendix L).

In presenting these gross cost data, it is recognized that there is a danger that the results will be misinterpreted. To conclude that Alaska's DOC had the "best" correctional health care system in 1989 and South Dakota's the "worst," based on the amount expended, would be in error. The potential disparities in the way these data were collected as well as the lack of control for intervening variables such as differences in the cost of living (and cost of health care) among the states render such an interpretation specious.

Additionally, more is not always better. It may be that some of the systems that spend less are actually more efficient in monitoring and controlling their health care costs. A much more detailed cost study is needed before any reliable conclusions can be drawn about the relationship between quality of care and cost.

The primary value of these data lies in comparing the cost expended on health services annually within the same state over time. There are only two published studies that can be used for comparative purposes. Contact, Inc. conducted cost surveys in 1983 and again in 1986 that covered essentially the same variables as NCCHC's 1990 survey. The reported data from both Contact, Inc. surveys were reformatted to conform to NCCHC's data for comparative purposes. While all of the limitations of the Contact, Inc. cost surveys are not known, based on the information provided, it is reasonable to assume that the same *caveats* apply as those discussed in conjunction with NCCHC's cost survey.

Table L-6, Appendix L, summarizes Contact, Inc.'s 1983 survey and Table L-7 its 1986 survey. In 1982, the 36 DOC jurisdictions reporting were spending an average of 7.2% of their total expenditures on health services at an average annual cost of $883 per inmate (see Table L-6). By 1985, the 46 DOC jurisdictions reporting were spending an average of only 6.8% on health services,but at an average annual cost of $1230 per inmate (see Table L-7, Appendix L). By 1989, these figures had climbed to an average of 9.5% and $1906 per inmate per year respectively for the 47 jurisdictions reporting (see Table XIII-1).

In order to make these comparisons more accurately, Table XIII-3 shows the changes in annual health cost per inmate from 1982-1989 and then 1985-1989, using data only from those states that reported in both years. From this chart, it can be seen that the average annual expenditure per inmate for health care increased from $893 in 1982 to $1814 in 1989, which represents a difference of $921 or an average growth of 103.1% over the seven year period. For the four year period of 1985-1989, average annual health expenditures per inmate increased from $1235 to $1906 or 54.3% ($671). In both instances, the rate of increase was well above the annual inflation rate and hence, undoubtedly represents real expansion in the extent of staff, services etc.[18]

The best comparison of health care costs, though, is seen in those jurisdictions that reported expenditures for all three time periods (see Table XIII-4). There were 31 such states. Of these, four

TABLE XIII-1
COMPARISON OF 1989 CORRECTIONAL HEALTH SERVICE COSTS BY STATE

STATE†	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION	FISCAL YEAR††	COMMENTS
AL	134,888,444	9,493,748	7.0	792	11,990	1988-89A	
AK	94,500,000	8,643,000	9.1	3,381	2,556	1988-89B	
AZ	221,675,400	24,551,201	11.1	1,913	12,836	1988-89B	
AR	55,782,785	9,495,347	17.0	1,595	5,954	1989-90C	
CA	1,593,256,000	149,660,000	9.4	1,953	76,633	1988-89B	
CO	99,203,000	7,277,599	7.3	1,154	6,306	1988-89B	
CT	195,896,302	18,643,344	9.5	2,108	8,845	1989-90C	
DE	74,326,900	4,781,100	6.4	1,524	3,138	1988-89B	
FL	694,287,968	95,766,619	13.8	2,706	35,386	1988-89B	
GA	320,763,218	27,404,345	8.5	1,648	16,631	1988-89B	
ID	29,797,400	2,847,504	9.6	1,560	1,825	1989-90C	
IL	437,700,000	34,100,000	7.8	1,570	21,714	1988-89B	
IA	60,845,599*	4,982,875*	8.2	1,618	3,079	1988-89B	*INCLUDES $1,226,987 IN NON-DOC DOLLARS
KS	210,000,000	9,916,000	4.7	1,640	6,048	1988-89B	
KY	117,000,000	7,500,000	6.4	1,210	6,200	1988-89B	
LA	205,342,717	10,395,142	5.1	831	12,505	1988-89B	
ME	11,999,372	2,235,135	18.6	1,870	1,195	1988-89B	
MD	245,514,787	16,713,211	6.8	1,226	13,630	1988-89B	
MA	226,450,000*	21,175,000*	9.4	2,379	8,900	1989-90C	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
MI	689,449,480*	75,000,687*	10.9	2,636	28,451	1988-89A	*INCLUDES MENTAL HEALTH SECURITY COSTS
MN	115,339,305	6,254,049	5.4	2,157	2,900	1988-89B	
MO	166,050,089	11,409,617	6.9	907	12,573	1988-89B	
MT	22,287,160	1,717,927	7.7	1,665	1,032	1988-89B	
NE	44,504,585	4,212,439	9.5	1,795	2,347	1988-89B	
NV	52,696,523	8,621,933	16.4	1,764	4,887	1988-89B	
NH	22,237,822	1,746,660	7.9	1,941	900	1988-89B	
NJ	391,574,000	37,364,000	9.5	2,016	18,538	1988-89B	
NM	92,303,300	8,236,800	8.9	2,900	2,840	1989-90C	
NY	1,094,159,100*	111,799,700*	10.2	2,249	49,711	1989-90D	*INCLUDES $30 MIL. FROM MENTAL HEALTH AGENCY
NC	319,888,293	34,747,160	10.9	1,973	17,610	1988-89B	
OH	688,400,000	39,600,000	5.8	1,366	29,000	1988-89B	
OK	142,289,266	9,093,988	6.4	909	10,000	1988-89B	
OR	128,689,876*	10,245,482*	8.0	1,868	5,484	1989-90C	*INCLUDES $1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
PA	269,913,000	25,235,000	9.3	1,429	17,662	1988-89B	
RI	48,130,805*	3,399,953*	7.1	1,711	1,987	1988-89B	*ADULT POPULATION ONLY
SC	183,732,201	19,479,068	10.6	1,387	14,049	1988-89B	
SD	36,123,357	1,013,393	2.8	787	1,287	1988-89B	
TN	229,628,000	14,427,500	6.3	1,962	7,354	1988-89B	
TX	508,000,136*	95,838,477*	18.9	2,262	42,365	1988-89E	*INCLUDES $16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
UT	61,677,566	2,331,752	3.8	1,174	1,986	1988-89B	
VT	26,000,000	1,387,000	5.3	1,558	890	1989-90C	
VA	384,733,767	19,500,000	5.1	1,500	13,000	1988-89B	
WA	213,542,450	18,648,840	8.7	2,664	7,000	1989-90C	
WV	21,308,964*	1,603,512*	7.5	1,035	1,550	1988-89B	*ADULT POPULATION ONLY
WI	158,201,700*	10,800,000*	6.8	1,695	6,373	1988-89B	*INCLUDES $2.9 MIL. FOR MENTAL HEALTH SERVICES
WY	13,961,191	1,122,205	8.0	1,264	888	1988-89B	
FBP	960,490,600	114,345,162	11.9	2,392	47,804	1988-89A	
AVERAGES:	$257,756,222	$ 24,569,436	9.5%	1,906	12,890		

N=47; †(NO DATA FOR HI, IN, MS, AND ND); ††KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89.

TABLE XIII-2
COMPARISON OF LINE ITEMS INCLUDED IN
1989 HEALTH SERVICES COST DATA BY STATE

STATE	HEALTH SERVICE COST DATA INCLUDES: HEALTH CARE STAFFING	SPECIALTY CARE	HOSPITAL-IZATION	EQUIPMENT	SUPPLIES	PHARMACEU-TICALS	EMERGENCY TRANSPORT	RENOVATION /REPAIR	OVERHEAD ITEMS	COMMENTS
AL	X	X	X	X*	X	X	X		X	*EXCEPT NEW FAC. EQUIP.
AK	X	X	X	X	X	X	X	X*		*EXCEPT MAJOR RENOVATIONS
AZ	X	X	X		X	X	X			
AR	X	X	X	X	X	X	X	X*	X	*REPAIR ONLY
CA	X	X	X	X	X	X	X	X		
CO	X	X	X	X	X	X	X		X	
CT	X	X	X	X	X	X				
DE	X	X	X	X	X	X	X	X		
FL	X	X	X	X	X	X	X		X	
GA	X	X	X	X	X	X	X			
ID	X	X	X	X	X	X	X	X	X	
IL	X	X	X	X	X	X	X			
IA	X	X	X	X	X	X	X	X	X	
KS	X	X	X	X	X	X	X	X	X	
KY	X	X	X	X	X	X	X	X	X	
LA	X	*	*	X	X	X	X	X	X	*COVERED BY OUTSIDE AGENCY
ME	X	X	X	X	X	X				
MD	X	X	X	X	X	X	X	X	X	
MA	X	X	X	X	X	X	X	X		
MI	X	X	X	X	X	X	X	X	X	
MN	X	X	X	X	X	X				
MO	X	X	X	X	X	X	X	X		
MT	X	X	X	X	X	X	X	X	X	
NE	X	X	X	X	X	X	X			
NV	X	X	X	X	X	X	X	X		
NH	X	X	X	X	X	X				
NJ	X	X	X	X	X	X	X			
NM	X	X	X	X	X	X	X	X		
NY	X	X	X	X	X	X	X			
NC	X	X	X	X	X	X	X	X	X	
OH	X	X	X	X	X	X	X			
OK	X	X	X	X*	X	X	X	X**		*LOCAL & EMERG. ONLY, **EQUIP. ONLY
OR	X	X	X	X	X	X	X	X	X	
PA	X	X	X	X	X	X	X	X	X	
RI	X	X	X	X	X	X	X			
SC	X	X	X	X	X	X	X	X	X	
SD	X	X	X			X	X			
TN	X	X	X	X	X	X	X		X	
TX	X	X	X	X	X	X	X	X*		*EXCEPT MAJOR RENOVATION
UT	X	X	X	X	X	X	PARTIAL			
VT	X	X	X	X	X	X				
VA	X	X	X	X	X	X	X			
WA	X	X	X	X	X	X	X	X	X	
WV	X	X	X	X	X	X	X	X		
WI	X	X	X	X	X	X	X	X	X	
WY	X	X	X	X	X		X	X		
FBP	X*	X	X	X	X	X	X	X	X	*INCLUDES PSYCHIATRIC, BUT NOT PSYCHOLOGICAL SERVICES
TOTALS	47	46	46	45	46	46	42	27	20	

TABLE XIII-3
COMPARISON OF CHANGES IN PER INMATE
ANNUAL HEALTH COST BY STATE BY YEAR
(1982-1989 AND 1985-1989)

1982-1989

STATE	$ 1989	$ 1982	$ CHANGE	% CHANGE
AL	792	1,053	(261)	-24.8
AK	3,381	1,202	2,179	181.3
AZ	1,913	2,141	(228)	-10.6
AR	1,595	968	627	64.8
CA	1,953	1,171	782	66.8
CO	1,154	1,249	(95)	-7.6
CT	2,108	591	1,517	256.7
DE	1,524	857	667	77.8
GA	1,648	919	729	79.3
ID	1,560	984	576	58.5
KS	1,640	706	934	132.3
LA	831	588	243	41.3
ME	1,870	1,095	775	70.8
MD	1,226	683	543	79.5
MN	2,157	947	1,210	127.8
MO	907	473	434	91.8
MT	1,665	710	955	134.5
NE	1,795	1,216	579	47.6
NH	1,941	1,648	293	17.8
NM	2,900	1,247	1,653	132.6
NC	1,973	886	1,087	122.7
OK	909	935	(26)	-2.8
OR	1,868	1,017	851	83.7
PA	1,429	836	593	70.9
RI	1,711	1,682	29	1.7
SC	1,387	593	794	133.9
SD	787	532	255	47.9
TN	1,962	737	1,225	166.2
TX	2,262	395	1,867	472.7
WA	2,664	845	1,819	215.3
WI	1,695	919	776	84.4
WY	1,264	479	785	163.9
FBP	2,392	1,214	1,178	97.0
N=33	$1,814*	$893**	$921	103.1%

*ADJUSTED WEIGHTED AVERAGE WITH 14 STATES DELETED
(i.e., THOSE WITHOUT 1982 DATA)
**ADJUSTED WEIGHTED AVERAGE WITH 3 STATES DELETED
(i.e., THOSE WITHOUT 1989 DATA)

1985-1989

STATE	$ 1989	$ 1985	$ CHANGE	% CHANGE
AL	792	1,239	(447)	-36.1
AK	3,381	2,423	958	39.5
AZ	1,913	1,269	644	50.7
AR	1,595	1,072	523	48.8
CA	1,953	1,893	60	3.2
CO	1,154	1,317	(163)	-12.4
CT	2,108	757	1,351	178.5
DE	1,524	1,150	374	32.5
FL	2,706	1,104	1,602	145.1
GA	1,648	1,259	389	30.9
ID	1,560	1,150	410	35.7
IL	1,570	1,257	313	24.9
IA	1,618	576	1,042	180.9
KY	1,210	575	635	110.4
LA	831	801	30	3.7
ME	1,870	1,161	709	61.1
MD	1,226	1,019	207	20.3
MA	2,379	1,725	654	37.9
MN	2,157	2,039	118	5.8
MT	1,665	772	893	115.7
NE	1,795	1,300	495	38.1
NV	1,764	1,040	724	69.6
NH	1,941	1,448	493	34.0
NJ	2,016	800	1,216	152.0
NM	2,900	2,600	300	11.5
NY	2,249	901	1,348	149.6
NC	1,973	1,398	575	41.1
OH	1,366	555	811	146.1
OK	909	968	(59)	-6.1
OR	1,868	1,173	695	59.2
PA	1,429	1,184	245	20.7
RI	1,711	1,762	(51)	-2.9
SC	1,387	717	670	93.4
SD	787	1,039	(252)	-24.3
TN	1,962	1,300	662	50.9
TX	2,262	1,700	562	33.1
VT	1,558	1,010	548	54.3
WA	2,664	461	2,203	477.9
WV	1,035	1,014	21	2.1
WI	1,695	1,019	676	66.3
WY	1,264	800	464	58.0
FBP	2,392	1,456	936	64.3
N=42	$1,906*	$1,235**	$671	54.3%

*ADJUSTED WEIGHTED AVERAGE WITH 5 STATES DELETED
(i.e., THOSE WITHOUT 1985 DATA)
**ADJUSTED WEIGHTED AVERAGE WITH 4 STATES DELETED
(i.e., THOSE WITHOUT 1989 DATA)

TABLE XIII-4
COMPARISON OF CHANGES IN PER INMATE
ANNUAL HEALTH COST BY STATE FOR THREE TIME PERIODS
(1982, 1985 and 1989)

STATE	$ 1989	$ 1985	$ CHANGE (85-89)	% CHANGE (85-89)	$ 1982	$ CHANGE (82-89)	% CHANGE (82-89)
AL	792	1,239	(447)	-36.1	1,053	(261)	-24.8
AK	3,381	2,423	958	39.5	1,202	2,179	181.3
AZ	1,913	1,269	644	50.7	2,141	(228)	-10.6
AR	1,595	1,072	523	48.8	968	627	64.8
CA	1,953	1,893	60	3.2	1,171	782	66.8
CO	1,154	1,317	(163)	-12.4	1,249	(95)	-7.6
CT	2,108	757	1,351	178.5	591	1,517	256.7
DE	1,524	1,150	374	32.5	857	667	77.8
GA	1,648	1,259	389	30.9	919	729	79.3
ID	1,560	1,150	410	35.7	984	576	58.5
LA	831	801	30	3.7	588	243	41.3
ME	1,870	1,161	709	61.1	1,095	775	70.8
MD	1,226	1,019	207	20.3	683	543	79.5
MN	2,157	2,039	118	5.8	947	1,210	127.8
MT	1,665	772	893	115.7	710	955	134.5
NE	1,795	1,300	495	38.1	1,216	579	47.6
NH	1,941	1,448	493	34.0	1,648	293	17.8
NM	2,900	2,600	300	11.5	1,247	1,653	132.6
NC	1,973	1,398	575	41.1	886	1,087	122.7
OK	909	968	(59)	-6.1	935	(26)	-2.8
OR	1,868	1,173	695	59.2	1,017	851	83.7
PA	1,429	1,184	245	20.7	836	593	70.9
RI	1,711	1,762	(51)	-2.9	1,682	29	1.7
SC	1,387	717	670	93.4	593	794	133.9
SD	787	1,039	(252)	-24.3	532	255	47.9
TN	1,962	1,300	662	50.9	737	1,225	166.2
TX	2,262	1,700	562	33.1	395	1,867	472.7
WA	2,664	461	2,203	477.9	845	1,819	215.3
WI	1,695	1,019	676	66.3	919	776	84.4
WY	1,264	800	464	58.0	479	785	163.9
FBP	2,392	1,456	936	64.3	1,214	1,178	97.0
N=31	$1,848*	$1,394**	$454	32.6%	$906***	$942	104.0%

*ADJUSTED WEIGHTED AVERAGE WITH 16 STATES DELETED (i.e., THOSE WITHOUT EITHER 1985 OR 1982 DATA).

**ADJUSTED WEIGHTED AVERAGE WITH 15 STATES DELETED (i.e., THOSE WITHOUT EITHER 1989 OR 1982 DATA).

***ADJUSTED WEIGHTED AVERAGE WITH 5 STATES DELETED (i.e., THOSE WITHOUT EITHER 1989 OR 1985 DATA).

decreased the amount spent annually per inmate for health services between 1982 and 1989. Alabama showed the most substantial decrease between 1982 and 1989 (almost 25% less expended per inmate for health care in 1989). This decrease seems to have occurred in more recent years, since a comparison of Alabama's 1982 to 1985 figures shows an increasing trend. While all of the factors accounting for this decrease are not known, the Alabama DOC did put its health services out for re-bid in 1988 and selected a new contractor at a lower price. The other three states whose annual health expenditure per inmate declined over time are Arizona (-10.6%), Colorado (-7.6%) and Oklahoma (-2.8%).

In the remaining 27 states, the per inmate annual health cost increased over time and in virtually all cases, at a rate well above the rate of inflation. In fact, in eleven of these cases, the increase was over 100%. Texas had the most dramatic increase in its annual health expenditure per inmate -- a whopping 472.7% rise in the seven year period from 1982 to 1989. This state has had one of the longest running class action suits (the *Ruiz* case) involving unconstitutional conditions of confinement including health care. It is interesting to note that the time period of 1982-1989 corresponds with the dates of the appointment by the federal court of a special master and a monitor for health services.[19] Unquestionably, much of the increase in Texas' health expenditure is attributable to real expansion in the extent and type of services offered.[20]

On an average basis, these 31 states increased their per inmate annual health expenditure 104% in seven years. They spent $906 per inmate for health care in 1982, $1394 in 1985 and $1848 in 1989. For most of the states, it is fair to assume that the increase in expenditures reflects some increase in services, but the question is "How much?" Unfortunately, this question cannot be answered by the present study. It is hoped that future studies will examine correctional health care spending in greater detail and control for intervening variables such as the cost of living in different states, the rate of inflation and variations in the method of accounting. Additionally, it would be useful to have cost data broken down by program area (e.g., medical, dental and mental health care); by service (e.g., hospitalization, specialty care, laboratory, radiology); and by inmate age and illness categories.

D. Controlling Health Care Costs

One of the most pressing societal challenges today is controlling the cost of health care. Improvements in medical technology have increased the life-span of Americans, both of which in turn, have increased the costs of care. Health care costs have risen in recent years at a rate far exceeding inflation. In many areas, health insurance premiums are increasing 25 percent per year or more.[21] These factors and others have led a number of experts to consider rationing health care,[22] which gives rise to a host of legal and ethical issues about "who lives? who dies? and who pays?"[23] As seen in the preceding section, correctional health care costs in most states also have escalated. Health administrators are being pressured by their state legislatures or by their own correctional administration to control or even reduce expenditures. Thus, some discussion of controlling correctional health care costs is warranted.

There is a danger, though, that must be acknowledged. The status of prison health care even ten years ago was abysmally low in many states. Substantial increases in expenditures were necessary to bring the level of care up to an acceptable minimum. It is impossible to tell from the expenditures alone which of the states may have achieved this, which have not and which may have gone beyond the minimum. To talk about controlling correctional health care costs -- at a point when there is no assurance that what is being spent is sufficient to address patients' needs -- may be a disservice. As stated elsewhere in this book, the primary goal of correctional health systems should be to provide quality care on a timely basis in a cost-efficient manner. All three elements in the equation are important. If a state DOC does not have an effective health delivery system in place (i.e., one that is constitutional and meets contemporary standards of care), then reducing services to cut costs is not a viable option.

Assuming that a quality health care system is in place, there are two basic ways to contain costs. The first is to make the system more efficient (i.e., eliminate waste) and the second is to ration care (i.e., eliminate fat). Each of these is discussed below.

1. Improving Efficiency

Improving efficiency usually means adopting one or more of the managed care techniques used in the community to contain costs. One example is to

review inmate utilization patterns to determine whether certain services can be provided more effectively in-house or in the community. One cost containment specialist defines utilization management as follows:

> *Utilization management is a process to eliminate unnecessary medical care and direct care to the most cost effective setting appropriate for the condition of the patient. Utilization management is composed of: preauthorization of services to assure medical necessity and the appropriate setting; concurrent review of inpatient care to expedite discharge when an inpatient setting is no longer required; discharge planning to facilitate placement in the most appropriate setting; retrospective review of bills for accuracy; and case management, which manages costly or complex cases* (Brace, 1990:9).

As another example, examining inmates' utilization patterns coupled with a time-and-motion study may identify areas where existing staff can be used more effectively or reductions in staff can be made without affecting the quality of care or the extent of service. As stated in section B of this chapter, expenditures for staff represent the biggest portion of most health care budgets. Staffing patterns often are generated based solely on the size of the inmate population, but if the inmate utilization in a particular prison is low, the staffing ratio may be too rich. Another suggestion offered earlier is to look for more efficient combinations of staff. A physician, a PA/NP, a clerk and a computer may be less costly than two physicians in the long run.

Another "big ticket" item involves hospitalization and specialty care costs. If inmate utilization patterns are developed for these services by diagnosis, it should be possible (with the help of a computer) to compare charges by other hospitals and specialists for the same services and procedures. Contracts more favorable to the correctional system may be the result. Where there is more than one hospital in a given area to choose from, there may be some interest on the part of the hospital administration in providing a volume discount in exchange for a guaranteed patient base. This managed care technique has worked for some correctional facilities.[24]

There are a number of other managed care techniques used in the community for non-emergencies that may have applicability for corrections. These include prior approval of specific treatments and services, preauthorization of inpatient hospital care, second surgical opinions for elective procedures, requiring that surgery for certain procedures be performed only on an outpatient basis, and retrospective review of all hospitalizations and surgical procedures by a committee established for that purpose to ensure that the care provided was within the specified guidelines. The application of some of these techniques to the correctional setting has already begun. For example, the California DOC requires preauthorization of hospitalization using that state's Medicaid guidelines and the North Carolina DOC has embarked on an ambitious cost containment program that will be tied into that state's Medicaid review process.

Besides these suggestions, there are other areas of health delivery where cost containment strategies can be employed. Inefficiencies often exist in the purchase of supplies, pharmaceuticals and equipment. Stock-piling of supplies and medications, and ordering equipment, supplies and medications that are not needed for the level of care provided at a particular prison, are all too common. Computerized information systems that track the utilization of supplies and pharmaceuticals as well as provide inventory lists and expiration dates (where applicable) can reduce waste. Inventory lists for equipment can provide the administrator with information about what already exists on a unit, what is obsolete and what simply is not required for the level of care.[25]

2. Rationing Care

Most correctional health experts undoubtedly would agree with many of the above suggestions to improve efficiency. Eliminating waste is important to all of us as taxpayers. The subject of rationing care is more controversial, however. Nonetheless, it is a topic that is beginning to be discussed in correctional health care forums. In 1988, a paper by Anno, Faiver and Harness was presented at the Third World Congress on Prison Health Care that provided a preliminary model for decision-makers in determining how much health care for inmates is enough. In 1989, the Federal Bureau of Prisons conducted a special seminar on medical issues in corrections where repeated reference was made to the potential for utilizing the criteria established by

Medicaid and Medicare programs to guide health care for inmates.[26] A 1990 article in *CorrectCare* suggested the development of a limited "benefit package" for inmates based on guidelines developed by the managed care industry such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[27] And, as noted above, the North Carolina DOC has initiated a program whereby its correctional health delivery system literally will be tied into the North Carolina Medicaid system's guidelines and review process.[28]

At bottom, what these discussions have in common is a suggestion for rationing inmate health care by developing a benefit package that specifies what is covered and what is not. They differ only as to which set of guidelines should be used: those of the managed care industry (Brace, 1990), those of Medicaid/Medicare programs (FBP, 1990 and North Carolina DOC, 1990) or ones developed specifically for correctional health services (Anno, Faiver and Harness, 1988).

Clearly, the courts have stated that inmates are entitled to "reasonable" or "adequate" care; they have not said inmates are entitled to the "best" care, but only to the care that is "needed." In confirming that inmates have a right to "reasonable medical care," a U.S. district court in *Mills v. Oliver* set forth this qualification:

> *This does not mean that every prisoner complaint requires immediate diagnosis and care, but that, under the totality of the circumstances, adequate medical treatment be administered when and where there is reason to believe it is needed. From the onset, it should be noted that the courts tend to treat "reasonable" and "adequate" as equivalent terms. Attempts at further qualifying the extent of care required do not set positive standards to be followed by prison physicians and officials, but rather take a negative approach, defining what is considered to be inadequate or unreasonable medical care. The courts have asserted that the deprivation or inadequacy of "essential" medical care is unreasonable.*

Since the courts have not developed "positive standards" for prison physicians and officials to follow (and are not likely to do so in the future), it is left to the field of correctional medicine to develop its own. While the standards published by professional associations (e.g., APHA, NCCHC) "...are extremely useful as guidelines in establishing a system of care, they do not provide much assistance in determining in individual cases what care must be provided and how much is enough" (Anno, Faiver and Harness, 1988:2). The development of "reasonable" criteria for rationing inmate health care is likely to be one of the most discussed issues of the 1990s.

It is not known how the courts may react to a "benefit package" for inmates that clearly states which services are provided and which are excluded. Caution should be exercised in the development of such a package and careful review by correctional health professionals and lawyers is needed prior to implementation. Still, the concept has merit and in these days of rapidly escalating health care costs, it is one that correctional health administrators can ill afford to reject out of hand.The use of community guidelines established by federally funded programs or the managed care industry has particular appeal, since it seems reasonable to argue that if the care provided by these programs is "good enough" for the general population, it should be "good enough" for the prisoner population.[29]

On the other hand, there are some unique aspects to corrections that may limit the wholesale application of existing care packages to the inmate population -- for example, the expected duration of confinement. A DOC administrator might decide not to provide a specific elective procedure to an individual inmate even if it were covered under the Medicaid benefit package because the inmate was due to be released a short time later. Similarly, the opposite decision might be reached for an inmate with a lengthy sentence even if the elective procedure were not covered in the community care plan.

As a way of initiating further dialogue on the topic of rationing care, it may be useful to discuss the preliminary conceptual model developed by Anno, Faiver and Harness (1988) for correctional health systems. They suggest a conceptual framework that defines a spectrum of services that ranges from those that should always be provided to those that may appropriately be denied. Examples of the former include all emergency care, medications for chronic conditions and dental treatment to relieve pain. Examples of the latter include "... purely cosmetic or luxury treatments, initiation of transsexual surgery, or expensive alternatives to conventional treatment such as gold dental crowns" (p. 10). "In between these extremes will be found diagnostic and therapeutic procedures that arguably should be provided to prisoners or whose

acceptability depends on one or more relevant circumstances" (p. 7). Obviously, it is this middle area that causes correctional health administrators the most concern.

In presenting their preliminary guidelines for this middle range of services, the authors assert that there are certain factors that should not influence the decision to intervene including "1. gender, 2. race or ethnic origin, 3. nature of crime, 4. behavior in prison, or 5. contributory behavior" (p. 14). The factors that should be taken into consideration by decision-makers in determining whether services and procedures in the middle range should be provided include:

1. *urgency of procedure (because of pain or risk of further deterioration),*
2. *expected remaining duration of incarceration,*
3. *necessity of procedure,*
4. *probability of successful outcome of treatment,*
5. *patient's desire (expressed or implicit) for the intervention,*
6. *expected functional improvement as a result of intervention,*
7. *whether the intervention is for a pre-existing condition,*
8. *whether the intervention is a continuation of previous treatment for a chronic condition, or is the initiation of a new course of long term treatment, and*
9. *cost.*

All of the factors need not apply in every case. When considered, the decision-maker must determine how much weight or value to assign (Anno, Faiver and Harness, 1988: 16-17).

After discussing each of these factors in some detail, the authors concluded that:

...ultimately, it may be possible to assign numerical values to the salient factors to further improve the usefulness of the model. However, before attempting to quantify the model, the authors believe it prudent to submit it in its conceptual form to their correctional health care colleagues for review. In the same way that the standards for correctional health care evolved, so, too, is consensus needed in deciding how much health care is enough (Anno, Faiver and Harness, 1988: 24).

It should be stressed that the conceptual model summarized above was a preliminary one and has not been pursued. Still, it may serve as a departure point for correctional health administrators interested in exploring legitimate ways to ration care.

E. Conclusions

This chapter presented some of the cost considerations that affect the provision of correctional health care. Owing to the technical expertise required in developing a budget and justifying it to the financing source as well as that needed to increase efficiency and control costs, it is well for a statewide health services director (HSD) to have some background in management, including managerial accounting. Further, a system of any appreciable size also should employ a fiscal officer (or staff) devoted to health services to advise and to alert the HSD to important budgetary and fiscal considerations.

Additionally, if the expertise does not exist in-house, it may be beneficial to hire a cost containment specialist on a consultant basis to review the delivery system for inefficiencies, set up a utilization database and suggest cost containment strategies. In regard to the latter -- especially as it relates to rationing of care -- it must be stressed that every assurance is needed that the existing delivery system meets contemporary standards of care before deciding that certain procedures or treatments will not be available to the incarcerated.

ENDNOTES

1. Numerous sources including the NIC Information Center, Contact, Inc. and the NCJRS were checked, but none had information indicating the availability of these dollars to fund health services for state prisoners. Additionally, a notice published in the July/August 1990 issue of *CorrectCare* requesting information on health care financing in corrections went largely without response, except by individuals and firms who were seeking similar information.
2. Interested individuals should contact the NIC Information Center and request a copy of NIC's current program plan that outlines available funding and services for training and technical assistance. The address is:

NIC Information Center
1790 30th Street, Suite 130
Boulder, CO 80301
(303) 939-8877

3. See Donabedian, 1973.
4. See further discussion of this concept in Chapter X.
5. See Feldstein (1983:8).
6. Economists refer to this phenomenon as *economy of scale* because it enables the organization to perform its function at a lower cost per unit of output as the organization size increases.
7. The *short run* is a time frame during which some costs can be varied and some cannot (see Welch and Welch, 1986). In the example given, a short run budget decision might be the addition of a nurse aide during the next fiscal year. No change can be made regarding the clinic building itself over the shorter time frame of this one fiscal year.
8. Budget practitioners often refer to this type of budget as a "zero-based budget" (ZBB) because the calculation is based on a discrete justification of program expenditures each budget cycle. The program administrator, under ZBB, justifies his/her program expenditures anew for each fiscal period. This process enables budget managers to evaluate competing programs on their relative merits and to select those judged higher in priority.
9. See Mendosa (1969).
10. See Donabedian (1980:7).
11. See Chapter XI for more information on management information systems (MIS).
12. See Chapter XII for more information on QA/RM programs.
13. The cost of x-ray per procedure is calculated by adding the cost of x-ray technician and repairs on equipment plus the cost of x-ray supplies and the cost of radiologist fees, divided by number of x-rays in the period. A better way would include a cost of depreciating the equipment in the numerator, though few state agencies do this.
14. This section was published in a somewhat different form in volume 9, issue 2 of the *Journal of Prison & Jail Health* in an article by Anno entitled "The cost of correctional health care: Results of a national survey." It is reproduced here with the permission of the publisher, Human Sciences Press, Inc.
15. Kenneth Thorpe as cited in Select Committee...(1989).
16. Health cost data for 1989 could not be obtained from the correctional systems in Hawaii, Indiana, Mississippi and North Dakota.
17. Technically, the Federal Bureau of Prisons is not a state; however, to avoid repetition, the terms "state" and "jurisdiction" are used interchangeably and "state" is intended to include the FBP where appropriate.
18. According to Kuemmerling and Howell (1990), the Consumer Price Index (CPI) for both 1982 and 1985 was 3.8%, whereas for 1989, the CPI was 4.6%.
19. Mr. Vincent Nathan and Ms. Jacqueline Boney respectively.
20. In this same seven year period, the Texas DOC's health delivery system went from one of the worst to one of the best. It has the distinction of being the only large state prison system to have the health delivery systems in all of its prison units accredited by NCCHC.
21. "Between 1984 and 1989, average per employee annual premiums more than doubled ($1,453 to $3,117)." See Select Committee...(1989).
22. See Kosterlitz (1989).
23. See the article by DePaul University (1989).
24. See Detore and Jenkins (1989).
25. See Chapter XI for more information on data management.
26. See Federal Bureau of Prisons (1990).
27. See Brace (1990).
28. See North Carolina DOC (1990).
29. An interesting legal question is raised by the adoption of a "community standard" such as the Medicaid system benefit package for prisoners. On the one hand, it does seem to provide a floor, below which correctional administrators should not go in approving health services for prisoners. It is conceivable, though, that in a given jurisdiction, the community standard, as represented by the Medicaid guidelines, may be lower than that required for prisoners by the Constitution. Such might be the case, for example, if accepted anti-viral therapies for the treatment of persons infected with human immunodeficiency virus (HIV) were not provided as a publicly-funded health care benefit. This has been the case in Puerto Rico. It remains to be seen whether the Eighth Amendment would require that an HIV-seropositive prisoner in that jurisdiction, who is medically appropriate, be offered this treatment. Similarly, in many states, abortion is not provided at public expense, yet at least one federal court has said that abortion must be available to inmates (see *Monmouth County v. Lanzaro*).

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CHAPTER XIV

CONCLUSIONS AND FUTURE ISSUES

The focus on the adequacy of care provided to prisoners is relatively recent. It was only in the 1970s that any systematic efforts to improve correctional health care were initiated. There were two parallel but separate forces behind this reform movement: the courts and the health professions themselves. Together, they are responsible for leading the field of correctional medicine into the twentieth century.

Both litigation and the voluntary programs of various health professional associations have resulted in dramatic changes in the extent and type of care received by prisoners. However, much remains to be accomplished. In some areas, correctional health care is still twenty to thirty years behind its community counterparts, and at the same time it is trying to catch up, external forces are at work that threaten the progress made.

The most serious crisis affecting corrections today is crowding. The war on crime, the war on drugs, fixed sentences, mandatory sentences, reduced use of alternatives to incarceration and the abandonment of early release programs in some areas have all resulted in the current population explosion in correctional facilities. Not only has this meant more inmates with which to contend in facilities whose services and resources already may be stretched, it also has meant that the inmates are older, sicker and staying longer.

Traditionally, inmates incarcerated in the United States have been from the lower socioeconomic strata. As a group, they have not had the benefits of adequate health care on the outside and they tend to participate in behaviors (e.g., substance abuse, smoking, poor nutritional habits, sedentary lifestyles) that place them at high risk for diseases such as AIDS, tuberculosis, STDs, heart disease, hypertension and renal failure among others. A substantial number of inmates are mentally ill or retarded as well. The correctional health profession is just now beginning to confront the issues surrounding inmates' special health needs and to examine options for providing specialty care, long-term care and services for the terminally ill.

As we move toward the twenty-first century, it is appropriate for those of us in the field of correctional medicine to embrace the challenge and goals of *Healthy People 2000*. We need to advocate for the inclusion of "the least of us" in the nation's broad health care mission to:

- *Increase the span of healthy life for Americans*
- *Reduce health disparities among Americans*
- *Achieve access to preventive services for all Americans.*[1]

There may be groups more deserving than inmates, but few more needy.

The challenge for correctional medicine over the next decade will be not only to "hold on to what we've got," but also to improve what we do. The latter can be accomplished by gathering adequate data, sharing information with colleagues, emphasizing preventive health issues, increasing the knowledge and skills of correctional health professionals, reducing unnecessary costs and improving the quality of the care and services provided. Each of these areas is discussed briefly below.

A. Data Collection

There are few activities less inspiring but more necessary than collecting data. In the absence of good data, it is difficult to determine whether inmates' current health needs are being addressed adequately and impossible to plan for the future. The necessity of data for decision-making has been stressed throughout this book. Decisions regarding the numbers and types of health staff needed, what services should be provided and where, the design of health facilities, the choice of equipment, cost control measures and quality improvement mechanisms all depend on the availability of reliable data that define the population to be served.

There also is a need for a national organization to assume responsibility for gathering data about the field of correctional health care as a whole. NCCHC has made a start in this direction by conducting a couple of national surveys on organizational structures, staffing and costs of health care in prisons, but a much broader and more systematic approach is required for such efforts to be useful. National data collection strategies should be implemented that emphasize annual reporting, so

that trends can be identified and projections made. The voluntary cooperation of correctional health staff in all DOCs is vital to this effort.

B. Information Sharing

It is important for correctional health professionals to share what they have learned with each other. The health programs and services of only a few DOCs are reflected in this book, because it was not possible to survey every DOC on every issue. The authors relied on their personal knowledge of a few DOCs and on information that was published. It is likely that correctional health staff in other DOCs are doing good things, but have not taken the time to write up their research or programs.

There are a number of professional journals including the *Journal of Prison & Jail Health* that would welcome articles about correctional health topics such as legal issues, ethical dilemmas, public health matters, morbidity and mortality data, special health problems of the incarcerated, cost control strategies, model treatment programs, the use of computers etc. Additionally, national clearinghouses such as the National Criminal Justice Reference Service and the NIC Information Center are always looking for reports, studies, policy manuals, planning documents etc. to add to their collections. Shorter articles or news items may be appropriate for periodicals such as *CorrectCare* or "CorHealth." Conducting a workshop at NCCHC's annual conference or ACHSA's multi-disciplinary conference is another way to share relevant information with colleagues as is cooperating in national surveys.

C. Emphasizing Prevention

A much greater emphasis should be placed on preventive health measures in corrections. Instituting environmental health activities, safety efforts, infection control programs and health education initiatives for both inmates and staff is one of the most effective long-term strategies for reducing disease and controlling health care costs.

Additionally, it is time to return some responsibility for their own health to the inmates. It is only by teaching inmates how to care for themselves that correctional health professionals will be able to get out from under their largely self-imposed burden of providing total care. There are a number of activities including medication administration, wound care, diabetes control, hypertension monitoring, dietary constraints etc. that are the primary responsibility of the patients themselves on the outside. Teaching inmates to participate in the management of their own diseases and conditions, along with general health education offerings geared toward disease prevention and wellness, benefit the inmates by improving their health status, the staff by reducing their workload and the DOC by reducing its costs.

D. Increasing Professionalism

Because corrections has had a history of offering second-rate health care, it often was assumed that the people who chose to work in this environment were second-rate as well. To the extent that that may have been true in the past, it no longer characterizes the profession. The involvement of mainstream health care organizations and the development of national standards have done much to elevate the qualifications of the practitioners who work in this field. Continued improvement of the knowledge and skills of correctional health practitioners should become a priority over the next decade. Attending in-service training programs, enrolling in formal continuing education offerings and participating in national conferences of various groups can do much to enhance the level of professionalism of practitioners. Other promising efforts to elevate the field of correctional health care include the emergence of academic programs targeted to this group of professionals and the initiation of a certification program by NCCHC.

At this point, there are a handful of universities that have formal course offerings in correctional health care. For example, Emory University has a master's degree in nursing with an emphasis in correctional health, the New York Medical College offers a master's in public health with a concentration in correctional health, and the University of Wisconsin provides a fellowship for primary care physicians leading to a master's degree in health administration with focus on correctional health issues. This latter master's program is open to baccalaureate trained health care providers as well. Other academic institutions including the University of Maryland School of Nursing and the University of Illinois School of Public Health are exploring the feasibility of formal degree programs in correctional health care.

Another approach to increasing professionalism among correctional health staff is the Certified Correctional Health Professional (CCHP) program

of the NCCHC.[2] NCCHC initiated a certification program for correctional health practitioners in 1990 and the first group took their examinations in November of that year. The CCHP certification is two-tiered: correctional health professionals start with a self-assessment exam to earn basic certification, and after three years, are eligible to sit for a proctored examination to achieve advanced status.

Both the CCHP program and the academic emphasis on correctional health care are in their infancy, but it is anticipated that these efforts and others over the next decade will help to establish correctional health care as a recognized specialty. The more correctional health care mirrors the elements of professionalism of the general health care field, the easier it will be to recruit and retain qualified staff.

E. Reducing Costs

According to Brandt (1990: 272), "[t]he United States spends more on health care than any other nation in the world." In 1990, U.S. health care expenditures exceeded $600 billion and are expected to reach one trillion dollars by 1995. Such costs are rising at four times the rate of inflation.[3] The United States also has the dubious distinction of leading the world in the rate of incarceration.[4] Neither the cost of health care nor the rate of incarceration are within the control of corrections, but both of these factors, coupled with the fact that prisoners are among those with the most substantial health needs, have created the current crisis in correctional health. Even though corrections cannot control such external influences, there are internal mechanisms that can be employed to reduce costs by eliminating waste and trimming fat from current expenditures.

A number of the managed care techniques used in the community have applicability for correctional health. Implementing second opinion and pre-authorization requirements, instituting utilization review practices and negotiating per diem contracts with hospitals help to keep health expenditures down. Emphasizing continuing training and education for health providers helps to improve their skills and performance and reduce the potential for liability. Developing computerized management information systems to track inventories of equipment, medications and supplies is another cost control strategy. Strengthening preventive health measures and instituting environmental health and safety efforts can impact on cost reduction in the long run. Finally, some DOCs are toying with the concept of defining health benefit packages for inmates that will delineate the range of services to be provided. DOCs should give careful consideration to implementing these and other cost control strategies.

F. Improving Quality

It is dangerous to focus on reducing costs without a concomitant concern for improving quality. Every DOC needs to ensure that it is providing an adequate level of health care to inmates at the same time as staff are looking for ways to cut costs. Cost control is not the same thing as reducing expenditures by eliminating needed personnel or services. The former focuses on making the system more efficient, the latter on making it less effective. Improving the efficiency and the effectiveness of the health care delivery system should be the DOC's primary goal.

Each DOC needs to institute programs to continuously improve the services it offers. Internal quality improvement efforts can raise staff morale, increase their performance and eliminate inefficiencies in the delivery system, all of which help to reduce costs. Periodic reviews by external groups such as national accrediting bodies help to ensure that the DOC's internal efforts to improve quality are keeping pace with national standards.

In sum, the focus of correctional health care over the next decade should be on doing what we do better. Gathering data to define our patients' needs and to increase our decision-making capacity, sharing what we learn with our colleagues, emphasizing preventive health measures, increasing the level of professionalism of providers, reducing unnecessary costs and implementing quality improvement programs will bring correctional medicine into the mainstream. Constant review of policies, procedures, practices, matériel and people will result in continual improvement of the field of correctional health care. The search for quality is a never-ending process, but like so much of life, the journey is as important as the destination.

ENDNOTES

1. See U.S. Public Health Service (1991).
2. Bernard P. Harrison, JD, who is recognized as the founder of the National Commission on Correctional Health Care, also is the individual who

initiated the Certified Correctional Health Professional activity.

3. From a 1990 study by Foster Higgins and Co. as cited by Brandt (1990).

4. See Elvin (1991).

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APPENDIX A

HEALTH SUMMARY FOR CLASSIFICATION, TDCJ

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SUBJECT: HEALTH SUMMARY FOR CLASSIFICATION

PURPOSE: To provide medical information to the classification committee with respect to housing, work assignment and disciplinary measures.

POLICY: A Health Summary for Classification form is completed on all inmates during the in-take process, and reviewed at the time of transfer to another unit.

PROCEDURE: The Health Summary form is completed or reviewed: 1) at the time of an inmate's arrival, 2) upon routine transfer, and 3) whenever changes occur in a patient's medical, psychiatric and/or mentally retarded status.

I. Intake--Diagnostic and Reception

A. Following the health appraisal (see Policy #3-10), a "Health Summary for Classification" form is completed on all new arrivals. A copy of the form and guidelines for completing it are found in Attachment A.

B. The original of this form is sent to the State Classification Committee along with a copy of the PULHES form.

II. Routine Transfers

A. Sending Unit

1. Upon receipt of the outgoing chain list, designated Health Services personnel review the medical records of all inmates on the list (see Policy #1-16).

2. If a Health Summary form has been completed and the inmate's health status has not changed, a new form need not be filled out. However, the existing form must be reviewed to ensure that the proposed unit of assignment is commensurate with the present unit in terms of meeting the patient's special needs, if any.

3. If a Health Summary form has not been completed, designated staff must fill one out for each inmate on the list.

a. Both copies of the form are placed in the medical record and forwarded to the receiving unit.

b. A "hold" must be placed on the transfer of any inmate if the proposed unit of assignment cannot meet the patient's need. This is accomplished by notifying the shift operations officer in charge, who, in turn, notifies the State Classification Committee.

B. Receiving Unit

1. Designated staff at the receiving unit pick-up the medical records for the incoming chain. The records are reviewed to ensure that any prescribed treatment continues uninterrupted (see Policy #3-3, Continuity of Care).

2. Additionally, the Health Summary forms are reviewed and copies provided to the unit Reclassification Committee.

III. Changes in Patients' Health Status

A. When a patient's health status improves or declines sufficiently that the treating practitioner believes the patient could be managed better at another unit, the following must occur:

1. A revised PULHES form and a new Health Summary for Classification form are completed to reflect the change in the patient's status.

2. A copy of these forms is sent to the office of the Medical Classification and Transfer Coordinator at the Health Services Annex along with an I.O.C. providing justification for the proposed transfer.

3. The Medical Classification and Transfer Coordinator screens the forms to ensure that sufficient information to justify the transfer has been provided. If not, the forms are returned for additional information. If so, the forms are sent to the Chief of Professional Services.

4. The Chief of Professional Services approves or denies all requests for medical transfers initiated by Health Services personnel.

5. If the request is denied, the forms are destroyed and the unit notified of the transfer denial.

6. If the request is approved, appropriate copies of the revised PULHES and the Health Summary form are sent to the State Classification Committee by the Medical Classification and Transfer Coordinator. The remaining copies of the forms are returned to the requesting unit for appropriate disposition, which includes inclusion in the medical record.

B. Whenever a change in an inmates medical condition occurs such that new job restriction(s) is (are) placed on the inmate by the physician, the following must occur:

1. A new Health Summary for Classification Form (HS-18) shall be completed immediately by the appropriate Health Services staff. Copies of new HS-18 forms should be forwarded to the unit classification office at least twice daily.

2. The inmate shall be given an administrative cell pass by the physician for the rest of that day, and in addition, Health Services shall place the inmate's name on the administrative lay-in list which is sent to the unit classification staff member responsible for entering lay-ins into the unit personal computer. The list shall indicate that the administrative lay-in is indefinite and that the purpose of the lay-in is classification review.

3. In the event that an inmate receives two lay-ins - a medical lay-in for health reasons and an administrative lay-in pending classification review - Health Services shall indicate on the lay-in list that the inmate received two separate lay-ins. The length of the medical lay-in will be specified and will be in effect until it expires. The administrative lay-in pending classification review will be in effect until the inmate has been reviewed by classification staff and the administrative lay-in cancelled.

4. An inmate who is unable to perform his/her current job assignment due to a temporary medical condition (e.g., cold, flu, high fever, etc.), as determined by appropriate Health Services staff, shall be given a medical lay-in which shall specify the length of time the inmate is to be excused from work. Health Services shall be required to complete a new Health Summary for Classification form whenever the length of a medical lay-in exceeds two weeks.

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Proponent: Chief of Professional Services

Approved: _____
(Date)

_____
Deputy Director for Health Services

Reference: NCCHC Standard P-32, Health Assessment (essential)
T.D.C. Administrative Directive AD-06.17, Health Summary for Classification

POLICY #3-11 - ATTACHMENT A

HEALTH SUMMARY FOR CLASSIFICATION

UNIT NAME: _____ EFFECTIVE DATE: _____ TDC #: _____

INMATE NAME: _____ HEIGHT: _____ WEIGHT: _____

DATE OF BIRTH: ____/____/____
DAY MONTH YEAR

I. UNIT ASSIGNMENT (CHECK ONE)

A. _____ NO RESTRICTIOI
B. _____ REGIONAL MEDICAL FACILITY
C. _____ EXTENDED CARE FACILITY
D. _____ PSYCHIATRIC ACUTE CARE FACILITY
E. _____ MROP SHELTERED FACILITY
F. _____ BARRIER-FREE FACILITY
G. _____ SUITABLE FOR TRUSTEE CAMP ASSIGNMENT
H. _____ SUITABLE FOR SAIP FACILITY
I. _____ OTHER (SPECIFY UNIT/REASON)

II. HOUSING ASSIGNMENTS

A. BASIC HOUSING (CHECK ONE)
1) _____ NO RESTRICTION
2) _____ SINGLE CELL ONLY
3) _____ DOUBLE CELL ONLY
4) _____ SPECIAL HOUSING (HOUSE WITH PATIENT APPROVED BY MEDICAL DEPARTMENT)

B. BUNK ASSIGNMENT (CHECK ONE)
1) _____ NO RESTRICTION
2) _____ LOWER ONLY

C. ROW ASSIGNMENT (CHECK ONE)
1) _____ NO RESTRICTION
2) _____ GROUND FLOOR ONLY

P	U	L	H	E	S

III. WORK ASSIGNMENT

A. _____ NO RESTRICTION
B. _____ DO NOT ASSIGN
C. _____ EXCLUDE FROM JOBS REQUIRING (CHECK ALL THAT APPLY):
1) _____ UNDERSTANDING OF COMPLEX INSTRUCTIONS
2) _____ AWARENESS OF ENVIRONMENT TO PREVENT INJURY
3) _____ STANDING FOR EXTENDED PERIODS OF TIME (TIME LIMIT WITHOUT REST ___ HR)
4) _____ LIFTING GREATER THAN _____ POUNDS
5) _____ EXCESSIVE EXPOSURE TO DIRECT SUNLIGHT
6) _____ EXCESSIVE EXPOSURE TO ENVIRONMENTAL POLLUTANTS (e.g., DUST, POLLEN, ETC)
7) _____ EXCESSIVE EXPOSURE TO ENVIRONMENTAL STRESSORS (e.g., LOUD NOISES, HIGH POPULATION DENSITY, ETC.)
8) _____ EXCESSIVE EXPOSURE TO HIGH INDOOR/OUTDOOR TEMPERATURES
9) _____ OTHER RESTRICTIONS (SPECIFY EXACT) _____

IV. DISCIPLINARY PROCESS:

A. _____ NO RESTRICTIONS
B. _____ CONSULT REPRESENTATIVE OF APPROPRIATE TREATMENT DEPARTMENT (e.g., PSYCHIATRIST, PSYCHOLOGIST, PHYSICIAN) BEFORE TAKING DISCIPLINARY ACTION

_____
(SIGNATURE AND TITLE OF REVIEWER)

COPY DISPOSITION
White Copy (Original) - Unit Classification
Yellow Copy - Health Services (Inmate's Health Record)

HS-18 (Rev. 4/89)

ATTACHMENT A
POLICY #3-11

GUIDELINES FOR COMPLETING THE HEALTH SUMMARY FOR CLASSIFICATION FORM

The purpose of the "Health Summary" form is to provide medical and psychiatric/ psychological information on each inmate to assist the classification committee in making appropriate assignments. The form is completed by a Health Services staff member from information available in the inmate's medical record.

The specific information to be placed in each item of the form is described below:

Unit Name -- The name of the unit where the inmate is currently housed and where the health review is taking place.

Date -- The date that the record review is taking place.

TDC # -- Exact six digit number

Inmate Name -- Full name of the inmate (Last name first).

Height & Weight -- For new arrivals, record from the "Report of Physical Examination" form. For reclassifications, obtain height from the same form, but record weight from the most recent place (e.g., progress notes).

Date of Birth: Day - Month - Year

I. Unit Assignment -- These categories are intended for more or less permanent placement, and not for temporary transfers due to remedial conditions.

A. **No Restrictions** -- This means that in terms of health considerations, the individual can be placed on any unit in the system.

B. **Regional Medical Facility (RMF)** -- This means that the inmate requires secondary (speciality) care, which is not available at all units. At present, the RMF's that are fully operable are Beto I, Huntsville, Jester III and Ramsey III for males and Gatesville for females.

C. **Extended Care Facility** -- This means that the inmate needs nursing home care. At present the only options are either Huntsville or Gatesville.

D. **Psychiatric Acute Care Facility** -- For inmates needing inpatient psychiatric care, all admissions will be through the Ellis II Unit or Mountain View Unit. Please note that only a physician can admit a patient to the psychiatric program at these two facilities.

E. **MROP Sheltered Facility** -- For mentally retarded inmates, the options are Jester III for males and Mountain View for females.

F. **Barrier-Free Facility** -- This category is intended for paraplegics and others who have motor impairments. At present, the only options are Goree for males and either of the female units.

G. **Suitable for Trustee Camp Assignment** -- Suitable for SAIP facility - PULHES does not include a "3" designator. Inmate able to participate in strenuous physical activity.

II. Housing Assignments - Information to complete these categories should be obtained from the physical exam, doctor's orders, and/or the Individualized Treatment Plan.

A. Basic Housing

1. No restrictions -- This means that from a health standpoint, the inmate can be assigned to any available housing.

2. Single Cell Only -- The following types of inmates must be single celled:

   a. medical inpatients if the physician recommends it;
   b. physically handicapped inmates if their Individualized Treatment Plan recommends it;
   c. inmates at MROP facilities if their ITP recommends it;
   d. psychiatric inpatients unless other housing is recommended for therapeutic purposes.

3. Double Cell Only -- For certain categories of psychiatric patients, single celling is contraindicated. For example, individuals who are potentially suicidal or who are extremely withdrawn or depressed or those who have a loss of contact with reality should not be isolated in a single cell.

4. Special housing (house with patient approved by medical department).

B. Bunk Assignment

1. No restrictions -- This means the inmate can be assigned either the uppor or lower bunk.

2. Lower Only - This category should be used for anyone whose medical condition makes it difficult to climb into an upper bunk. Examples include dwarfs, anyone who is feeble or infirm due to age or a condition such as arthritis, amputees, paraplegics, epileptics, individuals on medications causing sensory disturbances, obese individuals, enuretics, certain hypertensives, etc.

C. Row Assignments

1. No restrictions - This means the inmate can be placed on any row.

2. Ground floor only - This category should be used for individuals whose medical or psychiatric condition makes it difficult (or contraindicated) for them to climb stairs or be at higher row. Examples include inmates who are feeble or infirm due to age or a condition such as arthritis, those who have sensory disturbances due to medications, or who are suicidal, epileptic, paraplegic or have a condition such as chronic obstructive pulmonary disease.

III. Work Assignment -- These categories are intended to reflect more or less permanent conditions rather than temporary conditions due to an acute illness.

A. No restrictions -- This means that from a health standpoint the inmate can be assigned to any job.

B. Do not assign -- This means that the inmate should not be given a regular work assignment.

C. Exclude from jobs requiring:

1. Understanding of complex instructions -- This category applies to inmates who are mentally retarded.

2. Awareness of environment to prevent injury -- This applies to individuals who have serious visual or hearing impairments or seizure disorders or tactile impairments. For example, an individual who has an impaired sense of touch should not be assigned to the laundry or kitchen.

3. Standing for extended period of time -- This applies to geriatric inmates and those with peripheral vascular disease or congestive heart failure, for example.

4. Lifting greater than _____ pounds -- The number of pounds should be specified. The types of conditions where lifting would be contraindicated include hernias, upper extremity problems and geriatric status, for example.

5. Excessive exposure to direct sunlight -- Individuals on psychotropic medications or with a history of heat stroke should be noted in this category.

6. Excessive exposure to environmental pollutants -- Individuals with conditions such as chronic obstructive lung disease or asthma should be noted in this category.

7. Excessive exposure to environmental stressors -- Inmates with psychological problems such as anxiety disorders should be noted here.

8. Excessive exposure to high indoor/outdoor temperatures.

9. Other restrictions (specify exact).

IV. Disciplinary Process:

A. No restrictions -- This means that no special consideration needs to be made for health reasons prior to a disciplinary action being taken.

B. Consult representative of appropriate treatment department before taking disciplinary action -- This category should be checked for all diagnosed psychiatric patients, all mentally retarded offenders and for individuals with certain psychological problems such as suicidal inmates. In addition, certain medical conditions (e.g., patients on dialysis) may require special consideration prior to disciplinary actions. In this latter case, the physician must note this in the medical record.

Signature and Title of Reviewer -- The person filling out the form should sign his/her name and title, e.g., "Mary Jones, PA."

Copy Disposition -- This form is completed in duplicate. The original (white copy) goes to the Classification Committee and ultimately is filed in the inmate's confinement record. The duplicate (yellow copy) is retained by Health Services and filed in the inmate's health record.

Revised 4/89

APPENDIX B

ORGANIZATIONAL STRUCTURE OF HEALTH SERVICES IN STATE DEPARTMENTS OF CORRECTION (as of Fall 1989)

(Information obtained from a 1990 survey conducted by B. Jaye Anno for NCCHC)

ALABAMA

The entire Alabama prison system is contracted to a single for-profit contractor with respect to its health services. The health service contract includes medical, dental and mental health care. While all of the institutions are under contract service, there are still a few state employees that work at given institutions. For example, the DOC continues to provide some mental health services (e.g., psychological testing at intake, counseling for sex offenders) with its own employees. There is a central office staff for the contractor; however, line responsibility for the health professionals is from the unit staff to the contract administration. The contract administrator reports to the associate commissioner of the Department of Corrections on contract matters and to the president of the for-profit contract firm for his own supervision. At present, there is no employee of the Department of Corrections whose full-time job is to monitor the health contract.

ALASKA

In the state of Alaska, health services is a separate section within the division of programs. The division of programs also includes mental health services, rehabilitative services etc. There is a health services administrator who oversees the medical and dental areas. Mental health has a separate administrator. Both report to the director of programs who reports to the commissioner of the Department of Corrections. On the medical/dental side, the health service staff that work in individual institutions are administratively responsible to the wardens on a day-to-day basis; however, clinical supervision is provided through the central office staff. Thus, Alaska has a dual supervision model. This is true only for medical and dental services, though. At present, mental health staff at central office do not have line supervision over the mental health professionals that work in the institutions. The Alaska Department of Corrections uses a lot of contract personnel for professional services; however, no single institution is run under an outside contract. In most institutions, there are a number of people who work for the Department of Corrections directly and then others who have individual professional services contracts. There is a central office staff on the medical/dental side consisting of nine full-time and two part-time individuals that have statewide responsibilities.

ARIZONA

The Arizona Department of Corrections has a dentist who serves as the health director. He reports to the assistant director of human resources and development who reports to the director of the Department of Corrections. Health services includes medical, dental and mental health areas. It is a separate section within the DOC over which the health services director presides.

All of the personnel that work at the individual institutions are employees of the Department of Corrections. There is a total of five health services central office staff.

ARKANSAS

The Arkansas system has a mixed organizational model. There is a for-profit contract that provides medical services to all of the institutions in the system, but the Department of Correction runs its own dental and mental health services. There is a health administrator who supervises the medical contract and also has line supervision over the dental staff that work at the individual institutions. He reports to the assistant director of treatment services who reports to the director of the Department of Correction. Mental health services are supervised by a parallel administrator, but they are not under health services *per se*. The medical/dental central office staff consists of only three individuals -- an administrator, a secretary and a person who is in charge of infectious disease control. There are four other individuals at central office who work on the mental health side.

CALIFORNIA

In California, the medical director is a physician who works out of central office. He reports to the deputy director of institutions who reports to the chief deputy of the Department of Corrections who reports to the director of the DOC. The medical director supervises the chief medical officer at each institution. The chief medical officers and the wardens do all the hiring and firing. There is a separate budget for each institution for health services. The systemwide medical director indicated that the health services staff work under a dual supervision model. The institutional chief medical officers go to him as the statewide medical director for clinical supervision, but for administrative matters and security functions, they operate under the wardens at the individual institutions. There are no institutions in California that are totally contract. All of the health staff at the individual institutions are employees of the Department of Corrections, albeit there may be some professional services contracts for individual providers. Health services includes medical, dental and mental health areas. There are only 24 individuals within the health services central office, which is unusual for such a large health system; however, most line supervision occurs at the institutional level through the chief medical officer.

COLORADO

Colorado has a PhD psychologist who serves as the health services director. He reports to a deputy director who reports to the director of the Department of Corrections. Health services includes medical, dental and mental health care. It is a separate division within the Department of Corrections. The health service director has line control over the health staff who work at the individual institutions. All of the staff at the individual institutions are employees of the Department of Corrections, although there are some physicians who work under individual professional services contracts. There is a small central office health staff of five individuals that provides overall supervision and support services to the institutional staff.

CONNECTICUT

Health services in Connecticut is a separate division of the Department of Correction that includes medical, dental and mental health care. The health services director is a physician who reports directly to the commissioner of the DOC. All of the institutions are served by health professionals who are employees of the DOC or work under individual contracts. No institution in contracted out for its health care. The number of central office staff devoted to health care is not known.

DELAWARE

Health services at all of the institutions in Delaware are provided by a single for-profit contract firm. There is a full-time administrator and a medical director who works part-time at the central office. They are on a par. These individuals provide supervision for the contract personnel working in the individual institutions. The contract includes medical, dental and mental health services. Both the statewide administrator and the medical director for the system report to an individual within the headquarters of the contract firm. The statewide medical director spends approximately 90% of his time doing clinical work in the facilities and only about 10% doing administrative work for the system as a whole. The contract firm has seven individuals as central office health staff. The DOC does not have an employee who serves as the full-time health services contract monitor.

FLORIDA

The health services director for the Florida system is a physician. Health services includes medical, dental and mental health care and is set up as a separate division within the Department of Corrections. The statewide medical director has line responsibility for the employees working in the individual institutions and reports directly to the director of the DOC. Out of the 35 major institutions in Florida, one is served by a for-profit contract firm. At the remainder, a majority of the health services staff are employees of the Department of Corrections, although again there are specialty and ancillary services that may be provided through individual professional contracts. Florida has a central health services staff of 34 and a regional staff of five.

GEORGIA

Health services in the Georgia Department of Corrections is under the direction of a health administrator who reports to the deputy commissioner of industries and programs who reports to the commissioner of the DOC. The administrator has an MA in counseling and oversees the medical and dental services. Mental health services are under the division of industries and programs also, but are separate from the medical and dental services. The Georgia Department of Corrections has a mixed system. A number of its facilities are contracted out to a large national for-profit contract firm. In the remainder, the employees work for the Department of Corrections itself. The health services administrator indicated that each institution has its own health services budget, but that he oversees the budget for all of the facilities. Clinically, staff are accountable to the state medical or dental director and administratively, they are responsible to the wardens at the individual institutions. There are 12 central office health staff.

HAWAII

Hawaii has a statewide health services director who is a physician. She is responsible for medical, dental and mental health services, although the latter are provided by the Department of Health, Mental Health Division. There is a small central office staff of four individuals who provide support services to the institutional health care personnel. Health services were described as being a separate division within the Department of Corrections. The statewide medical director indicated that she has line supervision for the health services staff and that the central office concentrates on the development of policies and procedures and other statewide support activities. Each of the institutions within the Hawaii Department of Corrections has its own separate budget, though. Hawaii does not have any institutions operated by outside for-profit contract firms. The health services personnel that work in the institutions are mostly employees of the Department of Corrections for medical and dental services or the DOH for mental health services. Again, however, there are a number of physicians who operate under individual professional services contracts.

IDAHO

Health services in Idaho are headed by a PA who has responsibility for medical, dental and mental health services. He reports to the director of the Department of Correction. He is the only health individual that works in central office; nonetheless, health services were described as constituting a separate division within the Department of Correction. The health services director indicated that he had line responsibility for the health staff working in the institutions and also was responsible for the overall health services budget. All of the individuals providing health services at the institutions are employees of the Department of Correction with the exception of some specialists and other physicians who work under personal professional services contracts.

ILLINOIS

The health services director for the Illinois Department of Corrections is a physician. He is responsible for overseeing medical, dental and mental health services. Health services is a separate department within the Bureau of Employee and Inmate Services. The medical director reports to the deputy of this bureau who reports to the director of the Department of Corrections. In terms of its organizational structure, it is a mixed system. Some of the institutions in the system are run primarily by outside for-profit contractors, some are run by not-for-profit contractors and some have primarily state employees. At any given institution, there might be mixture of both contract and state employee staff. There are six institutions where primarily all of the health staff are state employees and 14 where primarily all of the health services staff are employees of private contractors. There is a strong central office system. Clinical supervision is provided through the statewide health services director and then administratively, health service staff are responsible to the wardens at given institutions. There are 12 central office staff who set policy, monitor contracts, provide technical assistance, do educational programming, perform quality assurance etc.

INDIANA

Indiana has a health services administrator who oversees the medical, dental and mental health programs for the state. He reports to the director of program services who reports to the commissioner of the Department of Correction. He is the only central office health employee. At the given institutions, health services staff are responsible to individual wardens and each institution has its own budget. None of the institutions has an outside contractor. All of the health services personnel work for the Department of Correction with the exception, again, of some professional service contracts for physicians, nurses and others.

IOWA

Iowa has a physician who serves as the part-time statewide medical director and the balance of his time as the medical director at a given institution. Approximately 55% of his time is spent on departmental matters (where he reports to the director of corrections) as opposed to institutional matters (where he reports to the superintendent). Health services staff at each facility are responsible to the individual superintendents. The medical director does not directly supervise any staff on a statewide basis, although he does supervise those that work at the institution where he is the medical director. Medical, dental and mental health services are all overseen by the chief medical officer at each institution. There are no other central office staff that work on a systemwide basis. There is one institution that is entirely under a for-profit contract for its health services. The remaining seven institutions all utilize Department of Corrections employees for their health service personnel, although again there may be some physicians who have individual professional services contracts.

KANSAS

There is one individual who serves at the health services director for the state. She reports to the deputy secretary of programs who reports to the secretary of the DOC. She is a health administrator and is the only Department of Corrections' employee at the central office in health services. Her role is to serve as the contract monitor. All of the Kansas institutions' health services are contracted out to a single for-profit firm. The contract includes medical, dental and mental health services. The contractor has eight individuals at central office who provide support to the institutional health staff.

KENTUCKY

In the state of Kentucky, a pharmacist serves as the health services director. He reports to the director of the division of operations who reports to the commissioner of adult institutions who reports to the secretary of the Department of Corrections. He is responsible for overseeing medical and dental services, but mental health services are handled through a separate area of the DOC. He is the only health individual that operates in central office and his role is primarily to develop policies for the system. Other than that, each institution has its own budget and health services staff are responsible to individual wardens. None of the institutions in Kentucky are currently being served by outside for-profit contractors. All of the employees work for the

Department of Corrections, although there may be some individuals who have professional services contracts.

LOUISIANA

Louisiana has a physician who spends one day a week as a health care consultant to the system, but there is no health services director *per se*. Each institution has its own part-time medical director and its own health services staff. All staff are responsible to the individual wardens. The wardens have line responsibility and also oversee the health care budgets within their own institutions. Health services includes medical, dental and mental health services. There are no outside contractors providing care to the institutions. Instead, all of the individuals work for the Department of Public Safety and Corrections except for some specialists who work under professional services contracts. There is no central office staff for health care.

MAINE

In Maine, there are no central office staff specifically devoted to health services. There is one individual whose title is "Director of Correctional Programs". He oversees medical services, mental health services, recreational services etc. He is responsible for all treatment programs, not just medical. He estimated he spends 15% of his time dealing with medical issues. In terms of the organizational structure, health services are provided at each institution. The individual wardens have line responsibility for the staff and each of them has his own health services budget. Medical, dental and mental health services are included and all are overseen by the wardens at given institutions. In terms of personnel, there is one facility that is operated by a hospital. Other than that, most of the nurses are employees of the Department of Corrections. Maine contracts for physicians, dentists and even some nursing services.

MARYLAND

The health services director for Maryland is an RN who serves as the administrator. She reports to the assistant commissioner of field services who reports to the deputy commissioner of corrections who reports to the secretary of the Department of Public Safety and Correctional Services. She has medical, dental and mental health services under her in the sense that she is responsible for monitoring the health services contract. The entire system is contracted out to a major for-profit firm. The staff who work at the individual institutions are mostly contract employees, although there are a few state employees who work there as well. The health services central office in Maryland has 12 staff members.

MASSACHUSETTS

The health services director for Massachusetts is a health administrator who has an MBA. He reports to the deputy commissioner of corrections who reports to the commissioner. Health services is a separate division within the Department of Correction. The administrator has line responsibility for the health services staff and also oversees the health services budget. There are 17 individuals who work in the health services central office. While none of the institutions is

operated under a private for-profit contract, each of them has some contract personnel. There is a not-for-profit organization that supplies physician services, crisis mental health care and psychiatrists for the inpatient program under a contract with the DOC. There are also a number of individual professional services contracts. The remainder of the individuals working in health services are employees of the Department of Correction. In Massachusetts, health services includes medical, dental and mental health services.

MICHIGAN

Michigan has a physician as the health services director for the system. She reports directly to the director of the DOC. Health services is a separate bureau (division) within the Department of Corrections. The physician director has line responsibility for health services staff and the budget is a centralized one. None of the institutions are served via an outside contractor. All of the employees that work in health services work for the Department of Corrections, except there are some individual professional services contracts for physicians and some pharmacy services. Health services in Michigan includes medical, dental and mental health care. There is a total of 13 central office staff members.

MINNESOTA

For the Minnesota Department of Corrections, there is a statewide health care administrator. This individual oversees medical, dental and mental health services. He administers the inpatient budget and oversees vendors for the system as a whole; however, each facility has its own budget for outpatient services and the health services staff are responsible to individual wardens. The statewide administrator does not have line responsibility for the staff that work at the institutions. All of the individuals working in health services are employees of the Department of Corrections except for some specific professional services contracts. The central health services staff includes only a statewide administrator and one other part-time individual. The administrator reports to the director of institution support services who reports to the deputy commissioner of institutions who reports to the commissioner of the DOC.

MISSISSIPPI

Mississippi does not have any statewide health services employees. Instead, at each institution, the health services staff are responsible to individual wardens. Each facility has its own health services budget. At each institution, health services includes medical, dental and mental health care. There is a medical director at each institution who is responsible for all three services. None of the institutions contracts out its health services. All of the employees work for the Department of Corrections.

MISSOURI

The health services director for the Missouri Department of Corrections is an administrator. She reports to the director of the division of classification and treatment who reports to the director of the DOC. Health services operates as a separate section within the Department of

Corrections. The administrator has line authority over the health services staff working in the institutions and also oversees a central budget. In Missouri, health services includes medical and dental care, but not mental health. The latter services are on a parallel but separate level within the DOC. The Missouri system does not have any institutions where health services are delivered wholly under contract. Rather, the health services professionals are all employees of the Department of Corrections with the exception of some local providers who have individual professional contracts. There are eight people in the central office who work in the health service area.

MONTANA

Montana has only a part-time medical director who serves statewide functions. This individual is a full-time employee of the system, but spends 90% of his time working in an institution and only 10% of his time consulting on statewide matters. There are only three institutions in the state of Montana and the health services staff within those institutions are ultimately responsible to the individual superintendents, although there is a head medical person at each facility. Contractual services by an outside firm are not used in this system. The health services professionals are employees of the Department of Institutions, Corrections Division or work under individual contracts. Medical and dental services operate under a single department, but mental health services are separate with a separate director. There are no other central or regional office health staff in the Montana system.

NEBRASKA

In Nebraska, the health director is an administrator with an MBA. He has line responsibility for some institutional health services staff, but not for others. None of the institutions is served by a contract as far as its health services are concerned. The health professionals are all Department of Correctional Services employees except for some specialty consultants. In Nebraska, health services includes medical and dental care, but mental health services are supervised by a chief psychologist. The health administrator and the chief psychologist are on an equal level organizationally. There is no central office health staff with the exception of the health services administrator, who also has institutional responsibilities.

NEVADA

The health services director for the state of Nevada is a physician who reports to the director of the Department of Prisons. He spends about 70% of his time on administrative matters and the rest on clinical issues. Health services in Nevada is a separate division within the Department of Prisons. The medical director has line responsibility over the health services staff and there is an administrator who deals with budget matters. None of the institutions in Nevada are served by an outside health services contract. The health professionals are all employees of the Department with the exception of some specialists who have individual professional services contracts. Health services includes medical, dental and mental health care. There are nine central office health staff.

NEW HAMPSHIRE

The medical director in New Hampshire is a psychiatrist who reports to the commissioner of the DOC. He does court ordered evaluations and also treats patients at the secure psychiatric unit. About 50% of his time is spent in administrative departmental matters. The health services in New Hampshire are essentially the responsibility of the individual wardens, although the medical director does provide some clinical supervision. Health services includes medical, dental and mental health care. All of the health professionals are employees of the Department of Corrections with the exception of some specialists who have individual professional services contracts. There are only two central office health staff.

NEW JERSEY

The director of health services is an individual with a master's degree in clinical psychology. He reports to the assistant director and then the director of the office of institutional support services who reports to the commissioner of the Department of Corrections. Health services in New Jersey includes medical, dental and mental health care. It is a separate section within the Department of Corrections in the sense that the health services professionals report to the health administrator for professional and procedural issues. On a day-to-day basis, the superintendents in the individual institutions are responsible for employees. This system has both centralized and institutional activities. None of the institutions is operated under an outside contract as far as its health services are concerned. The health professionals are employees of the Department of Corrections, although, again, there are specialty groups that provide some services on a contract basis and there are some contracts for ancillary services. There are 18 central office staff in health services.

NEW MEXICO

The health services director is a physician who reports to the deputy secretary and then the secretary of the New Mexico Corrections Department. The organizational structure changed in October 1989 when health services were put out to bid. A national for-profit contract firm now provides medical and dental services for the system, but the DOC continues to provide its own mental health care. The system's medical director was retained and serves as the full-time contract monitor.

NEW YORK

The health services director in New York is a physician. He is responsible for both medical and dental services. Mental health services are provided through the Office of Mental Health, which is not a part of the Department of Corrections. Health services operates as a separate division within the Department of Corrections and as of April 1990, there was a central budget for health services to be administered by the medical director's office. The medical director reports directly to the commissioner of the Department of Correctional Services. None of the institutions in New York are under a separate contract for their health services. The health professionals are all employees of the DOC with the exception of some individual specialty contracts. There are 12 people in the central office for health services and 12 at the regional level.

NORTH CAROLINA

The health director is an administrator with a degree in hospital administration. He oversees both medical and dental services, but there is a chief of mental health who is on a par with the health administrator. Health services is a section within the Division of Prisons and the administrator reports to the director of the division of prisons who reports to the deputy secretary and then the secretary of the Department of Correction. The health services employees are responsible to individual wardens at the unit level. The central office sets policy and decides clinical issues, but there is no line supervision of the institutional health staff by the central office health staff. There are no contract services in use in North Carolina with the exception of some specialty contracts. The central office staff for health services consists of 25 individuals. Also, there are a few area nurse supervisors that operate on a regional level.

NORTH DAKOTA

The health services director for North Dakota is an RN who works only part-time on a departmental level. Mostly, she works at one of the institutions in North Dakota and reports to the deputy warden. Each of the institutions in North Dakota has its own budget and the personnel are supervised by the individual wardens. At each institution, health services includes medical, dental and mental health care. These professionals report to the health administrator within the institution and ultimately, to the warden. There are contract services through the university medical school. Interns come to the institutions for sick call. Also, pharmacy services are under contract as are some hospital services. However, other personnel work directly for the Department of Corrections and Rehabilitation.

OHIO

The health services director for the state of Ohio is a physician. He reports to the deputy director of internal affairs who reports to the director of the Department of Rehabilitation and Correction. While there is a central estimated budget, each institution is given a total budget that reflects health services line items as well. The central office staff do not have line responsibility for the health services staff. That rests with the wardens at the individual institutions. None of the Ohio institutions are served by contract health care. The health professionals are all employees of the DOC with the exception of a few nurses, physicians and some ancillary personnel who operate under individual professional services contracts. Health services in Ohio includes medical and dental care, but not mental health. The latter services are provided under the Department of Mental Health. There are four individuals who work in the central office and two regional staff devoted to health services matters.

OKLAHOMA

The health services director in Oklahoma is a physician. He reports to the associate director of the Department of Corrections who then reports to the director. Health services has a centrally controlled budget. It was described as being a separate section within the Department of Corrections. The concept of dual supervision is used. The health staff at the institutions are clinically responsible to the statewide medical director and administratively responsible to the

wardens in the individual institutions. All of the health professionals working in the individual units are employees of the Department of Corrections with the exception of some specialty physicians. Also, pharmacy is contracted out. There is a total of seven individuals working in the health services central office.

OREGON

The health services director for the state of Oregon is a registered nurse. She reports to the assistant director of the institutions branch who reports to the director of the Department of Corrections. Health services has its own budget and the administrator has line supervision for the health services staff. It was described as being a separate section within the institutional branch. Health services includes medical and dental services, but not mental health. Most of the mental health care is provided by the Department of Mental Health, which is separate from the Department of Corrections. All of the health professionals working at the institutions are employees of the state of Oregon with the exception of a few individuals who work under professional services contracts. There is a total of three health services individuals working in central office.

PENNSYLVANIA

In Pennsylvania, the chief of the health care division is a health services administrator with a master's degree. He reports to the director of the bureau of treatment services who reports to the deputy commissioner of programs who reports to the commissioner of the Department of Corrections. Pennsylvania has a mixed system. Some of the institutions are run by the Department of Corrections and some are run by private for-profit contractors. Each facility has its own budget. Health care staff are responsible to the superintendent and the health administrator at each institution. Health services includes medical, dental and mental health care. There are only two individuals who work in the central office.

RHODE ISLAND

There is a health care administrator position, but it has been vacant for a couple of years. On paper, this position reports to the deputy assistant director of rehabilitative services who reports to the assistant director of adult services who reports to the director of the DOC. In effect, the deputy assistant director of rehabilitative services oversees health services, which includes medical, dental and mental health care. The Rhode Island Department of Corrections has its own health services employees supplemented by individuals with professional services contracts. They report to the health administrator position when it is filled or to the deputy assistant director when it is not. Aside from the health administator position, there are no other central office health positions.

SOUTH CAROLINA

In South Carolina, there is an RN who serves as the health services director. She reports to the deputy commissioner for program services who reports to the commissioner of the DOC. Health

services is a separate department within the division of programs in the sense that the health director has line responsibility for health services staff and oversees the central budget; however, it is a mixed system in the sense that some of the institutions, (five to be exact), are under a for-profit contractor and the remaining 27 are run by the Department of Corrections itself. The health director monitors the performance of the contractor in addition to supervising the health services staff. In South Carolina, health services includes medical, dental and mental health services. There is a total of 12 central office staff.

SOUTH DAKOTA

South Dakota does not have any individual who oversees its health services on a statewide basis. There is an RN at one of the institutions who serves as the health services supervisor and she reports to the associate warden for programs. The health services personnel in the South Dakota facilities report to the individual wardens. Health services includes medical, dental and mental health care. All of the employees work for the Department of Corrections, although there are also contracts with local providers.

TENNESSEE

The medical director for the Tennessee Department of Correction is a physician. He reports to the director of institutional resources who reports to the assistant commissioner of adult institutions who reports to the deputy commissioner who reports to the commissioner of the DOC. Basically, health services personnel are responsible to individual wardens. There is one institution where the medical director has line supervision, but in the other institutions, he does not. There is also one facility that is operated under a for-profit contract. In the remaining facilities, the physicians are consultants, while nurses and ancillary personnel are mostly state employees. Health services includes medical and dental care, but usually not mental health; however, there are some institutions where mental health is a part of health services. In others, the individuals work directly for the wardens. There is a central office health staff of six individuals, but no regional staff.

TEXAS

In Texas, the health services director is a physician. This individual has deputy director status and reports directly to the head of the Department of Corrections. Health services is a separate division within the Department of Corrections. The medical director has line supervision over the individuals working in the institutions and there is a separate health services budget. As in other instances, a concept of dual supervision is used wherein health services staff also are responsible administratively to the wardens in the individual institutions, although they report through a unit health authority. At the time these data were collected, there were no institutions that were under a for-profit contract; however, there are now four units that are operated totally by outside contractors including health services. In the remaining institutions, health staff are employees of the Department of Corrections with the exception of some consultant physicians who have individual professional services contracts. Medical, dental and mental health services are included within the division. Texas has a large central office health staff (70), 18 regional office health staff and 2700 unit health staff.

UTAH

Utah does not have a central health office *per se*. There is a health services administrator who works at one of the institutions who is responsible for administering the budget for health services and within that institution, the administrator is the supervisor of the health services staff. In the main, however, health services personnel are responsible to the individual wardens. The administrator reports to the bureau chief of support services who reports to the director of institutional operations and then to the deputy director and finally the director of the Department of Corrections. Medical, dental and mental health services are included under a single administration. None of the institutions in Utah are under an outside contractor. Health professionals are employees of the Department of Corrections or work under professional services contracts.

VERMONT

Vermont has one individual with a degree in counseling who serves as the chief of clinical services at the central office. He reports to the director of program services who reports to the commissioner of the Department of Corrections. This system is a little different organizationally. For the most part, personnel are responsible to individual wardens. However, the health services administrator is responsible for insuring that the institutions comply with the statewide policies. There is a central budget for outpatient surgery and inpatient hospitalization, but each facility has its own budget for routine outpatient services. The health professionals work for the Department of Corrections or under professional services contracts. None of the institutions is served by an outside contractor. Medical, dental and psychiatric services are under the chief of clinical services. Other mental health staff work under a separate branch. There is no regional staff and, as noted above, only one person who works in central office.

VIRGINIA

In Virginia, the health services director is an administrator. He reports to the chief of operations for programs who reports to the deputy director of adult institutions who reports to the director of the Department of Corrections. The health services administrator does not have line responsibility for health care staff. Instead, they are responsible to the individual wardens. Each institution has its own budget, although it is administered through the central office. All of the health professionals are employees of the Department of Corrections or work under professional services contracts. Medical and dental services are under the health services administrator, but mental health is provided through another office that is comparable in structure. There is a total of five individuals who work in the central office in the health services section.

WASHINGTON

In the state of Washington, the health services director is an RN. He reports to the director of the division of offender programs who reports to the secretary of the Department of Corrections. The health services administrator serves primarily as a consultant to the individual institutions. Health services personnel are responsible to the individual wardens who provide line supervision. Each institution has its own health care budget. The health professionals working in the

Washington system are either employees of the Department of Corrections or working under individual professional services contracts. Health services includes medical, dental and mental health care. There is a total of five health staff in central office.

WEST VIRGINIA

West Virginia does not really have a central office for health services. There is one individual who serves as the director of treatment services, which includes medical, dental and mental health services. He reports to the commissioner of the DOC. At the unit level, however, medical and dental services are separate from the mental health services, which are provided through the Health Department. Most of the staff are responsible to individual wardens; however, one of the institutions is contracted out to a national for-profit firm. At the remaining institutions, there is a mixture of state employees, individual contracts for ancillary services and some professional services contracts.

WISCONSIN

Until recently, the organizational structure of the Wisconsin system was unique. It was the only DOC where health services were provided totally by a separate agency. Health services personnel all worked for the Division of Health and not for the Division of Corrections, although both were part of the same umbrella agency. The health services director was an RN who served as the administrator of the system. There also was a half-time medical director employed as a consultant. Wisconsin did not have any private contract firms providing health care. Within the individual institutions, the health professionals were all employees of the Division of Health with the exception of some professional services contracts for specialists and ancillary services. The Division of Health was responsible for the medical and dental services; however, within the Division of Correction, the bureau of clinical services provided mental health care. The health services administrator's responsibility was to coordinate with the Division of Corrections' personnel with respect to mental health matters. In the Wisconsin central office, there were ten individuals that worked on health services administration. In January 1990, a separate Department of Corrections was created. Health services was reorganized so that the health professionals are now employees of the Department of Corrections. The health administrator became the head of the Bureau of Correctional Health Care. She reports to the director of the division of program services who reports to the deputy secretary for operations who reports to the secretary of the new Department of Corrections. The Bureau of Clinical Services of the DOC continues to oversee mental health. With the exception of the change in organizational structure, other aspects of the health services system noted above remained the same.

WYOMING

Wyoming does not have a systemwide medical director. Each institution has its own budget and line authority. The institutions contract with local physicians for care and the nursing personnel are employees of the Board of Charities and Reform, which includes corrections. They report directly to the wardens. Health services at the institutions includes medical, dental and mental health care. None of the Wyoming institutions has an outside contract firm providing health services. There are no central or regional office health staff.

APPENDIX C

SAMPLE ORGANIZATIONAL STRUCTURE CHARTS

CHART C-1
SAMPLE ORGANIZATIONAL STRUCTURE
OF HEALTH SERVICES IN DOC's CENTRAL OFFICE

HEALTH ADMINISTRATOR AS HEALTH SERVICES DIRECTOR

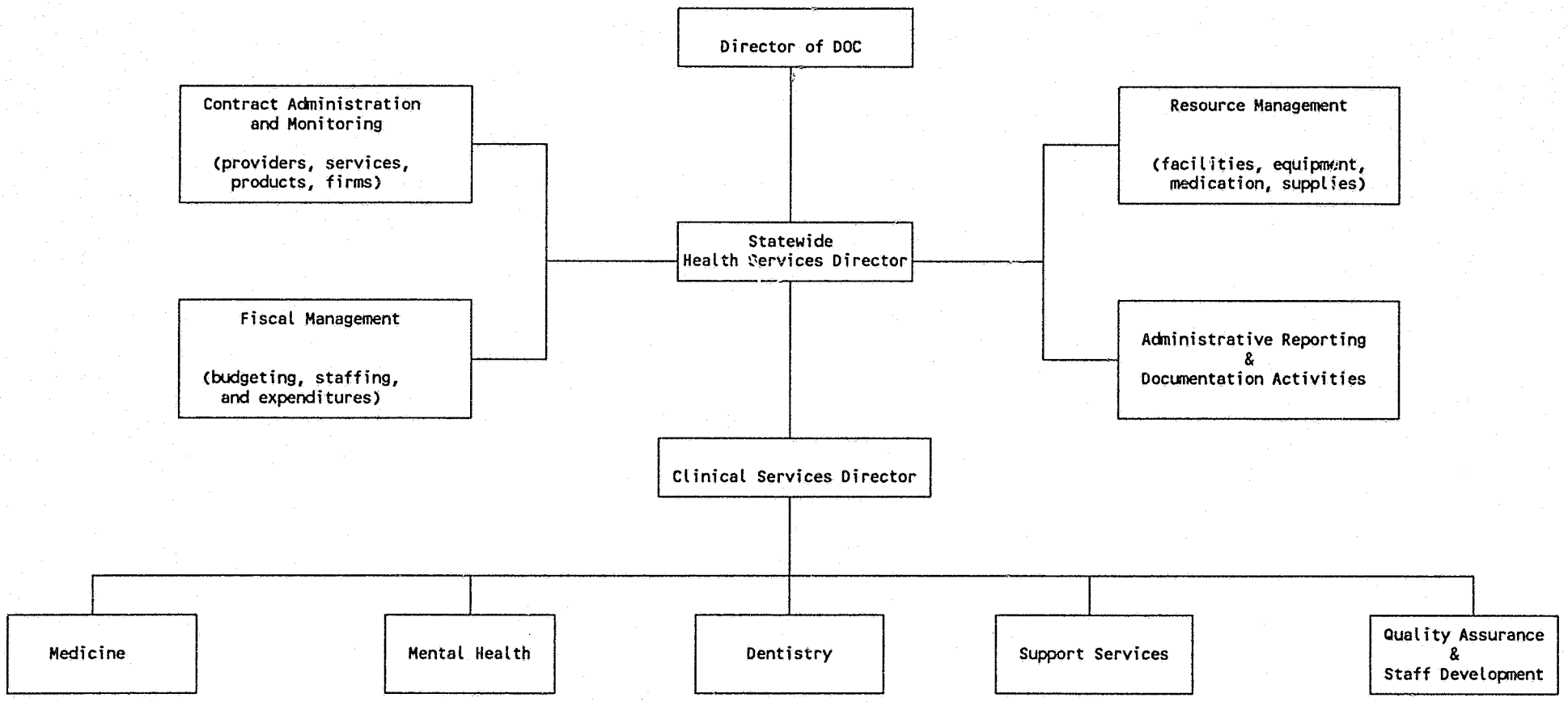


CHART C-2
SAMPLE ORGANIZATIONAL STRUCTURE
OF HEALTH SERVICES IN DOC's CENTRAL OFFICE

PHYSICIAN AS HEALTH SERVICES DIRECTOR

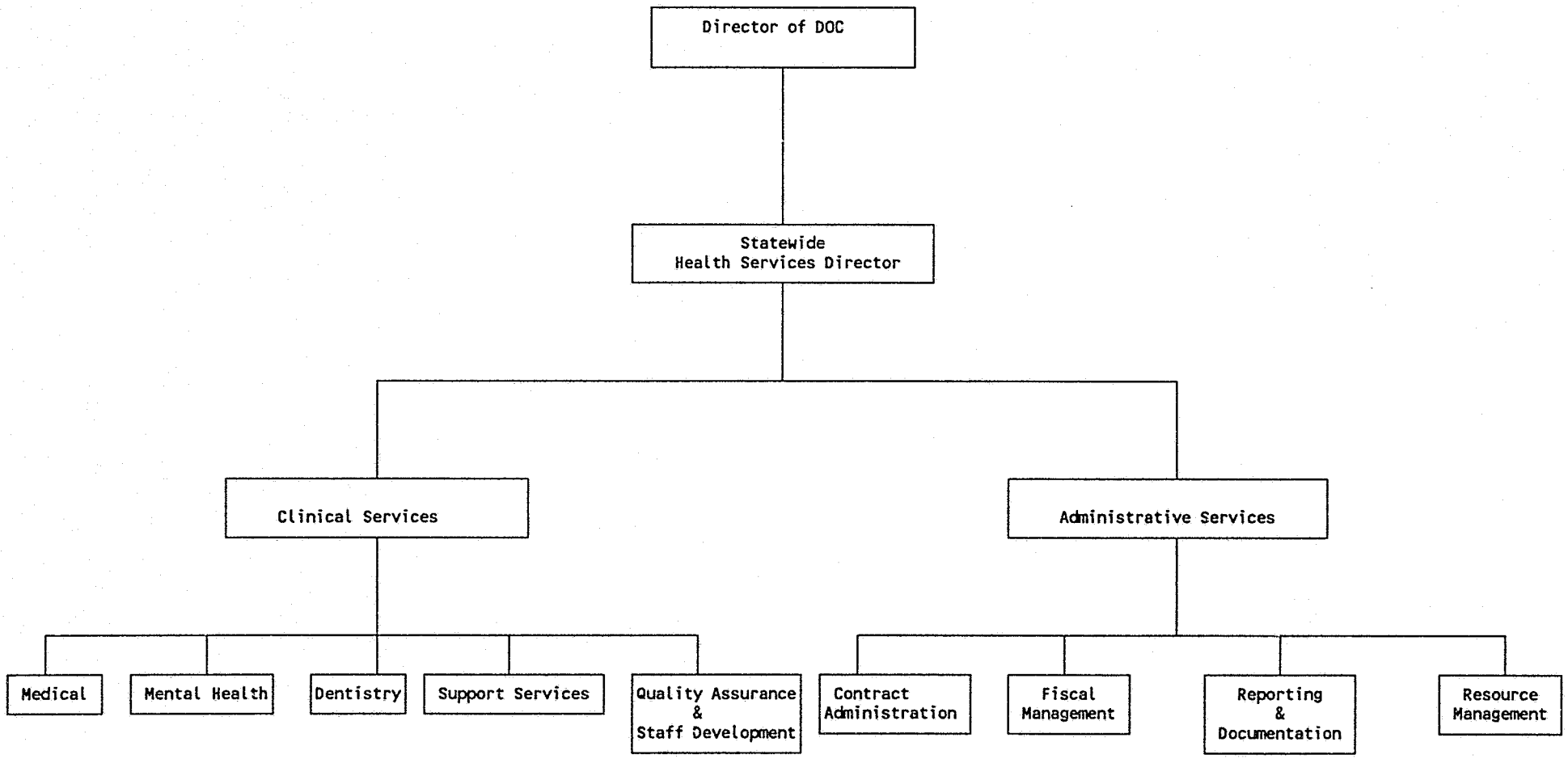


CHART C-3
SAMPLE ORGANIZATIONAL STRUCTURE
OF UNIT HEALTH SERVICES

PROFESSIONAL ADMINISTRATOR AS UNIT HEALTH AUTHORITY

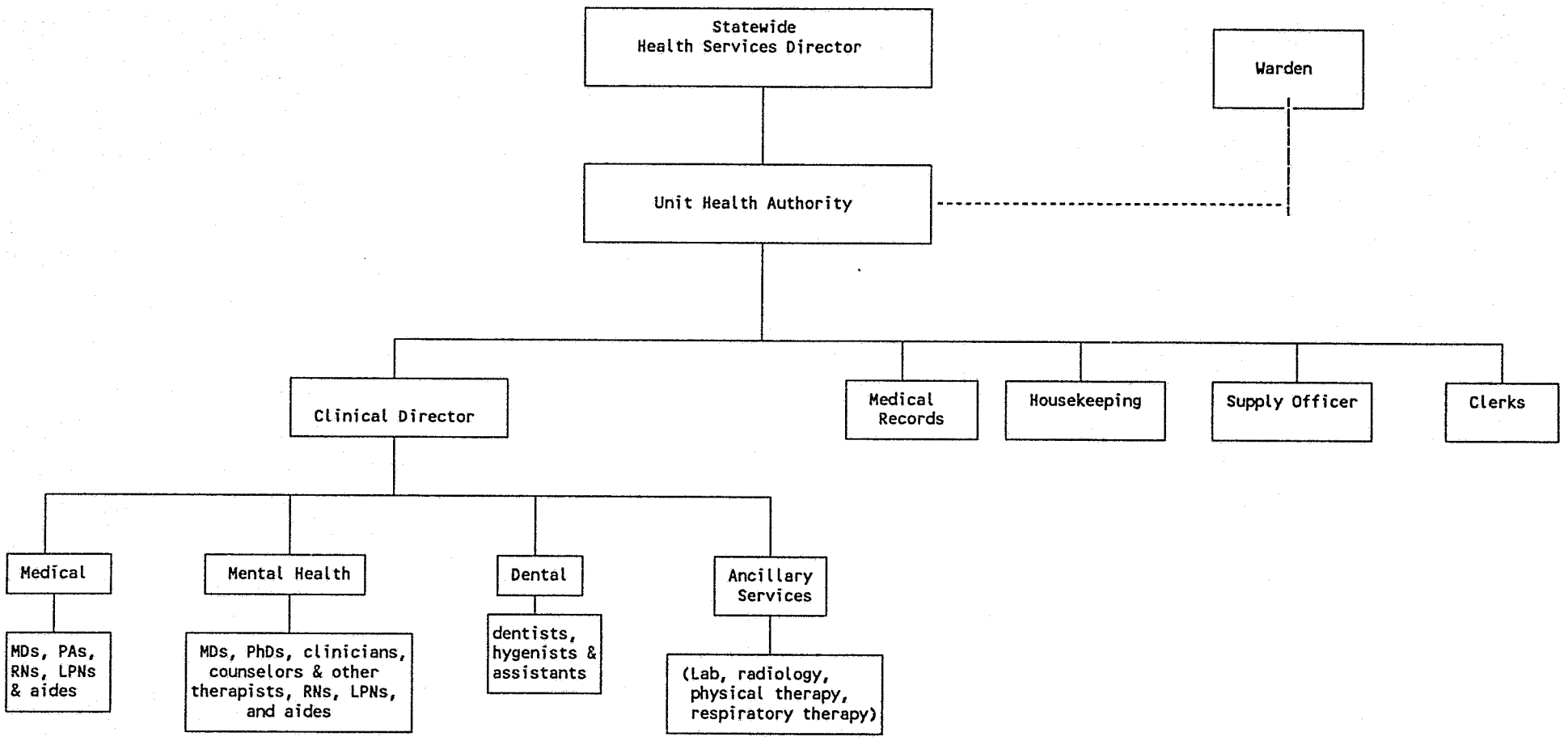


CHART C-4
SAMPLE ORGANIZATIONAL STRUCTURE
OF UNIT HEALTH SERVICES

PHYSICIAN AS UNIT HEALTH AUTHORITY

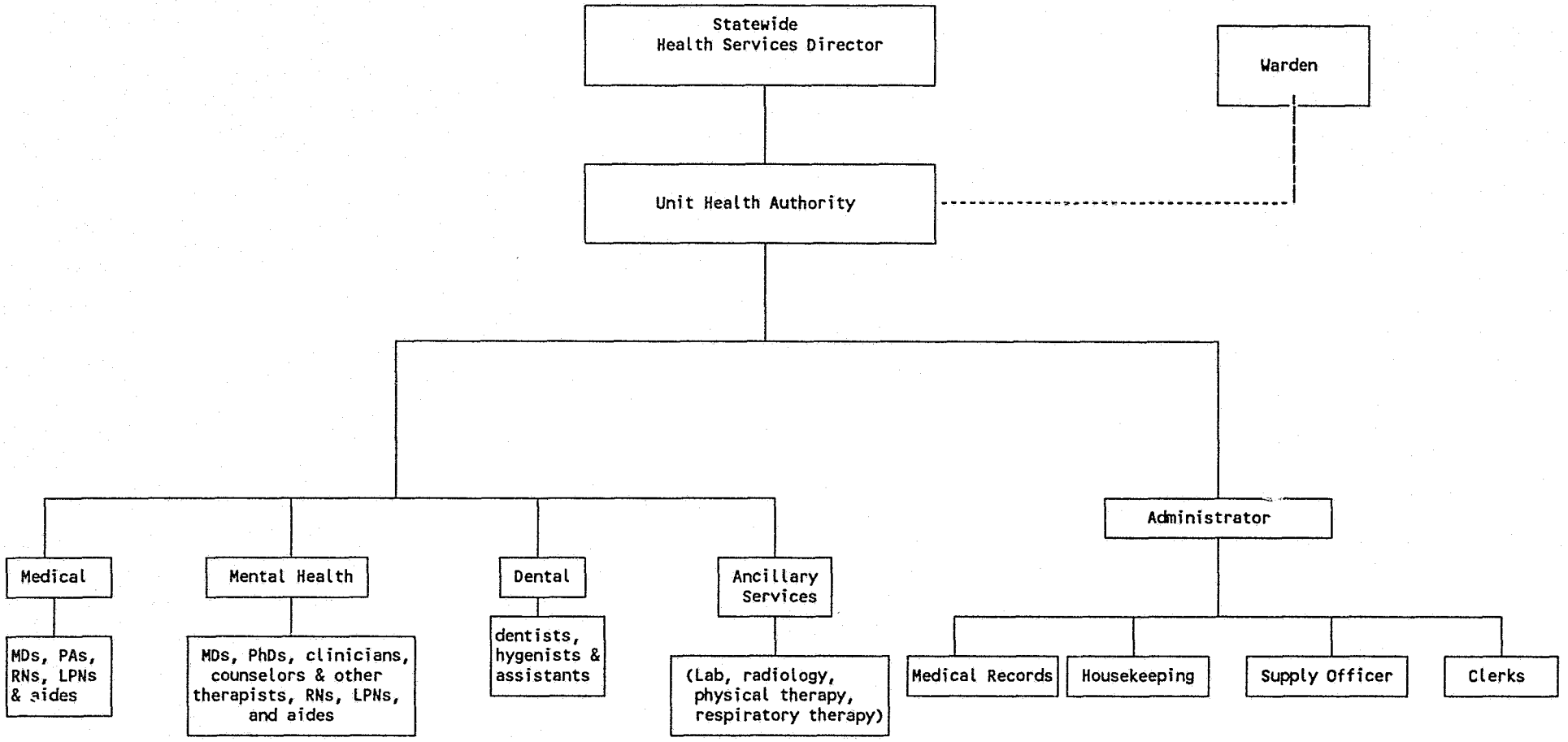
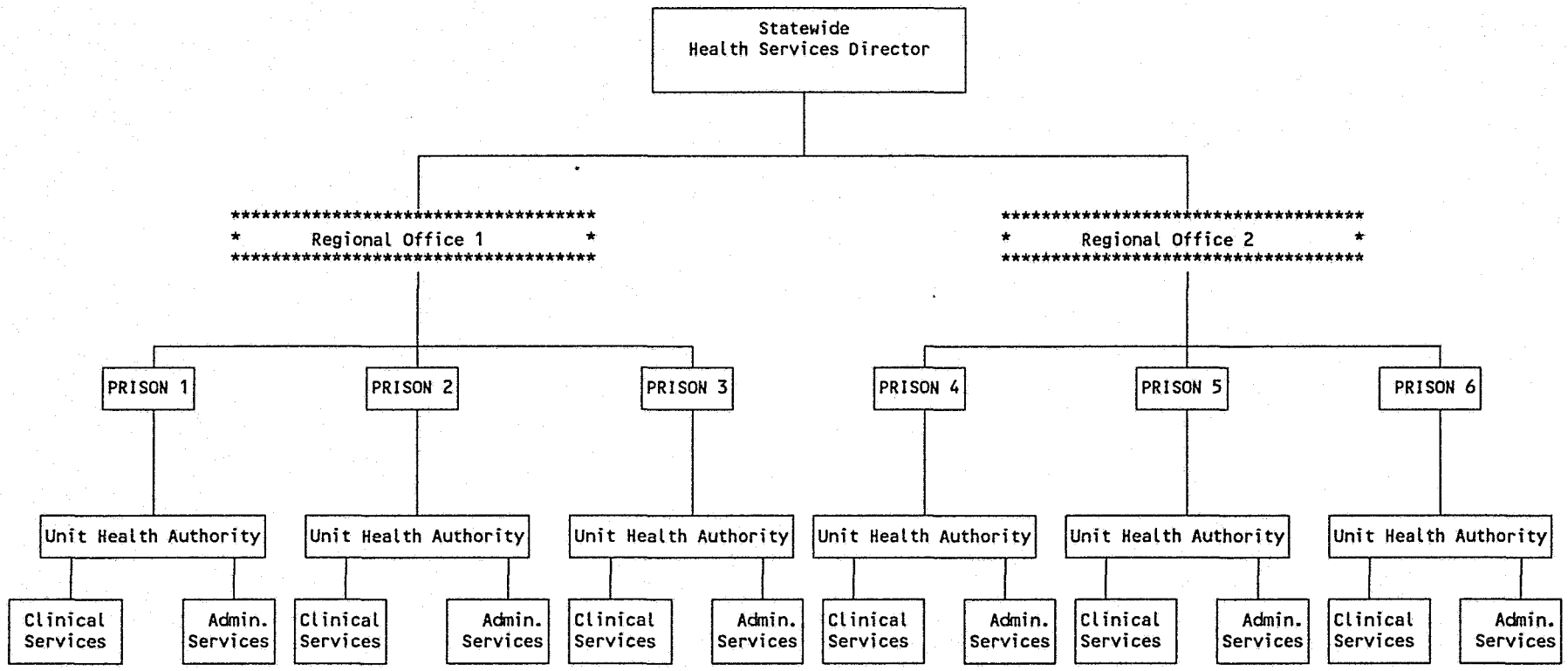


CHART C-5
SAMPLE REPORTING STRUCTURE OF UNIT HEALTH SERVICES



APPENDIX D

COVERAGE FACTOR CALCULATION SUMMARY*

STEP		EXAMPLE	
1.	Regular days off per employee per year (usually 52 weeks per year x 2 days off per week).....	104	_____
2.	Remaining work days per year, which is 365 minus #1	261	_____
3.	Vacation days off per employee per year.....	10	_____
4.	Holiday days off per employee per year.....	16	_____
5.	Average number of sick days taken per employee per year.....	5	_____
6.	Average number of in-service training days per employee per year.....	3	_____
7.	Additional initial training days for each new employee beyond in-service training in #6 above.....	10	_____
8.	Percent of employees employed one year or less.....	20	_____
9.	Number of other days off per year, such as for union meetings, litigation, military leave, special assignments, funeral leave, injury, etc.....	2	_____
10.	Total days off per year equals #3+4+5+6+9 to which is added #7 multiplied by #8.....	36+2	_____
11.	Number of actual work days per employee per year equals #2 minus #10.....	223	_____
12.	Coverage factor equals #2 divided by #11.....	1.17	_____
13.	Seven-day coverage ratio equals #12 multiplied by 1.4, which is 7/5.....	1.64	_____
14.	Continuous coverage ratio equals #12 multiplied by 168 [24 hrs x 7 days], and divided by the number of hours an employee works each week, not including overtime, which is usually 40.....	4.91	_____

*Reproduced from: Benton, F. Warren, Planning and Evaluating Prison and Jail Staffing. Volume I. Washington, D.C.: National Institute of Corrections. (1981)

APPENDIX E

COMPARATIVE ANALYSIS OF STANDARDS ON HEALTH CARE IN PRISONS

Introduction

The chart that follows summarizes some of the similarities and differences among the four sets of national standards governing health services that are used in correctional facilities in the United States. In all instances, the most recent version of the standards was consulted. Doing such a comparative analysis is complicated by a number of factors. For one thing, the types of facilities to which the different sets of standards apply is not the same. JCAHO's ambulatory care standards were designed for community facilities and thus, cover none of the elements specific to correctional institutions. APHA's standards are said to apply to "large state prisons serving major urban communities as well as small county jails in rural areas" (Dubler, 1986:viii). Only the ACA's and NCCHC's standards are designed specifically for adult prisons.

Additionally, the topics covered by the different sets vary widely. Hence, no attempt was made to compare every standard in each set with all standards in the other sets. To do so would have made a difficult task impossible. Instead, major topic areas were compared only with respect to certain elements.

Finally, three of the sets of standards (all except APHA's) are used in accreditation programs. Each organization weights its standards differently. ACA uses "mandatory" and "non-mandatory" designations, JCAHO has "key factors" and uses a weighted scale in calculating compliance, and NCCHC identifies "essential" and "important" standards. Thus, even where the content of a standard may be similar, the significance attached to it for accreditation purposes may vary.

In the chart, the standards are referenced in parentheses by the number appearing in the text or by page number. Where there is a designator as to the significance of the standard, the following key may be helpful.

Key

*	=	Used to designate JCAHO's "key factors."
E	=	NCCHC's essential standards
I	=	NCCHC's important standards
M	=	ACA's mandatory standards
NM	=	ACA's nonmandatory standards
p. or pp.	=	Page number(s)

There is one final *caveat.* In attempting to summarize data and compare basic requirements of the various sets of standards, certain nuances may have been ignored. The reader should not rely on this chart as the complete statement of these organizations regarding any issue. Instead, the original texts should be consulted and the standards read in their entirety.

System Elements	*ACA (1990)*	*APHA (1986)*
I. Management Concerns A. Legal Obligations	Requires facility to follow informed consent practices of jurisdiction. Allows health care to be rendered against inmate's will, if in accord with state and federal laws and regulations (#3-4372,NM). Prohibits experimental research on prisoners, but allows individual inmates to participate in clinical trials (#3-4373,NM). Recognizes the principle of confidentiality of the health record (#3-4377,NM).	Recognizes that inmates have a right to consent to and to refuse treatment (pp. 109-110). Specifies that confidentiality of health information should be maintained (pp. 111-112). Does not permit forcing mental health treatment except in an emergency or with a court order (pp. 42-43). Inmate participation in research not addressed.
B. Ethical Issues	Does not address role of health staff in evidence-gathering or disciplinary measures, except that conducting body cavity searches is permitted (#3-4185,NM). Requires all segregated inmates to be visited daily by health staff (#3-4246,NM). Requires classification to consider inmates' special needs (#3-4292,NM) and provides for information sharing from health authority to warden, although permissible circumstances not specified (#3-4377, NM). Specifies need for consultation between warden and physician prior to housing, program, disciplining and transfer decisions regarding mentally ill and retarded (#3-4369,NM).	Prohibits non-medical use of medical personnel in strip and cavity searches, forced transfers, evidence-gathering without inmate's consent, certifying wellness for punishment, and in executions (pp. 112-114). Requires daily visits of all segregated inmates by medical staff and weekly physician rounds (p. 10). Requires health information to be provided to classification committees to determine special housing needs (p. 8).
C. Documentation Needs	Requires quarterly meetings between warden and health authority; quarterly reports on health delivery system and health environment; and annual statistical reports (#3-4328,NM). Also requires policy and procedure manual governing health care operations with annual review (#3-4329,NM).	Policy and procedure manual addressing adherence to standards required (p. 105).
D. Quality Assurance Activities	Topic not addressed, except for standard on inmate grievance procedures (#3-4271,NM).	Requires both independent and internal audits of services and programs. Multi-disciplinary committee to meet at least every other month. Inmate complaints must be addressed (pp. 97-98).

JCAHO (1990)	*NCCHC (1987)*	*Comments*
Has a section on the rights and responsibilities of patients that provides for informed consent (RP.1.3* and RP.1.4*) and the right to refuse to participate in experimental research (RP.1.6.6*). Also has a section on research activities governing the circumstances under which it is permissible (p. 71). Requires confi-dential treatment of disclosures and records (RP.1.2*).	Like APHA's, NCCHC's standards recognize a right to refuse treatment (P-69,I) as well as a right to consent to treatment (P-68,I). Certain treatment (i.e., psychotropic medications) may be forced only in an emergency situation and then only when specific guidelines are followed (P-70,E). Inmate participation in ex-perimental research prohibited except where ethical, medical and legal guidelines are followed (P-71,I).	All four sets are fairly consonant on the issues of informed consent and confidentiality, although APHA's and NCCHC's provide the most specificity.
Topics not addressed.	Prohibits participation of correctional health professionals in body cavity searches for contraband and psychological evaluations of inmates for use in adversarial proceedings. Allows personnel to perform court-ordered lab or radiology procedures with inmate consent and to gather evidence in sexual assault if requested by victim (P-11,I). Prohibits health staff participation in punishment, but requires: pre-exam of inmates placed in disciplinary segregation as well as daily monitoring of their health status (P-50,E); 3 times per week checks of other segregated inmates (P-51,I); and on-going monitoring of inmates in disciplinary restraints (P-60,I). Also requires custody and medical staff to share information (P-07,I) and to consult on housing and program assignments as well as disciplinary measures and admissions to and transfers from institutions for all special needs inmates whether for medical or mental health reasons (P-08,I).	APHA's and NCCHC's standards (particularly the latter) provide the most guidance to health professionals in interfacing with correctional staff on inmates' health needs. Also, these two sets address the role of health staff in evidence-gathering and disciplinary measures while the other two basically do not. While ACA does address body cavity searches, it permits health professionals to conduct them whereas the standards of NCCHC and APHA expressly prohibit this activity for medical personnel.
Not specific to corrections, but has a section regarding the organization's governing body (pp. 23-25) and one on administration requiring policies, procedures and controls for health delivery (pp. 27-29).	Requires documented quarterly meetings between local health authority, prison administration and other relevant health and correctional staff regarding effectiveness of delivery system, health environment factors etc.; documented monthly meetings for all health staff; and statistical report at least annually regarding health services delivered (P-03,E). Also requires policy and procedure manual covering standards with annual review (P-04,E).	NCCHC's are the most stringent.
Has an extensive section (pp. 3-8) covering quality assurance (QA) activities. Provides very detailed instructions regarding components of QA program.	Requires at least monthly chart reviews by physician and at least quarterly meetings of multi-disciplinary QA committee (P-05,E). Also addresses external peer review program (P-06,I) and resolution of inmate grievances on medical matters (P-37,I). Most comparable to APHA's.	JCAHO's standards are the most comprehensive on QA matters and ACA's the least.

System Elements	ACA (1990)	APHA (1986)
E. Safety & Environmental Issues	Has whole sections covering building and safety codes (p. 39), environmental conditions (pp. 47-48), safety and emergency procedures (pp. 65-68), health and safety regulations (#3-4302,M; #3-4303,M) and inspections of food services (pp. 102-103), sanitation and hygiene (pp. 105-108), and work, health and safety standards for prison industries (#3-4401,M).	Has a large section on environmental health (pp. 61-94) that covers grounds and structures, services and utilities, special facilities, safety issues, hygiene requirements and inspections. Also has standards governing occupational health (pp. 55-60).
II. Service Delivery		
A. Resources		
1. Personnel	Health authority may be a physician, health administrator or health agency. If not a physician, there also must be a designated physician who makes final medical judgments (#3-4326,NM). States that all health professionals must be licensed certified or registered. Written job descriptions are required (#3-4334,M). Inmates are prohibited from performing patient care activities unless participating in a certified vocational training program (#3-4340,NM). Any students or interns must work under direct staff supervision (#3-4339,NM). Numbers and types of health staff not specified.	The principal medical authority must be a physician (p. 105). All health staff must be licensed or certified (p. 106). Written job description are required (p. 105). Inmates may be used in the health area only for janitorial services (p. 107). Staffing ratios not specified except for 1 FTE physician for every 200-750 inmates (p. 104).
2. Space and Equipment	Contains only a general statement that "space, equipment, supplies and materials for health services are provided and maintained as determined by the health authority" (#3-4333,NM).	Topic not addressed except for availability of reference materials for staff (p. 19).

JCAHO (1990)	NCCHC (1987)	Comments
Has a section on plant, technology and safety management (pp. 31-35) that includes adherence to safety codes, disaster planning, disposal of hazardous materials and wastes, equipment inspections and safety procedures, utilities etc.	Has a few standards addressing safety and environmental issues such as disaster planning (P-12,E), first aid kits (P-24,I), infection control (P-40,I), ectoparasite control (P-45,I), personal hygiene (P-49,I), environmental inspections (P-13,I) and sanitation of food service operations (P-14,I) and personnel (P-22,I).	For correctional health services, APHA's provide the most guidance and NCCHC's the least.
Does not specify type of person in charge. Requires licensure or certification of staff and written job descriptions (AD.1.2*). Requires role of students or post-graduate trainees to be defined if used (AD. 1.4*).	Health authority may be a physician, health administrator or health agency. If not a physician, there also must be a designated physician who makes final medical judgments (P-01,E). States that all health professionals must be licensed certified or registered (P-15,E). Written job descriptions are required (P-16,I). Inmates are prohibited from performing patient care activities, although they may make health care products (e.g., dentures, orthotics) under certain circumstances (P-23,E). Staffing ratios not specified except for 1 FTE physician for every 750-1000 inmates (P-17,I).	All sets require licensure and job descriptions. Differences are in level of staff serving as health authority and role of inmate workers. All four of these professional groups shy away from specifying the exact numbers and types of health care staff required. While previous publications sometimes indicated the number of staff needed based on the number of inmates in the facility on an average daily basis, more recent efforts have recognized that there is no simple formula for determining appropriate staff size. The number and type of health care personnel required by an institution is dependent not only on its average daily population, but also on the total number of inmates received during the course of a year, their varying lengths of stay and the particular health care needs of inmates (e.g., alcoholics, addicts, geriatrics) among other factors. See Chapter VI for a more complete discussion.
Topic not addressed.	Includes a standard on equipment, supplies and publications (P-25,I) that provides some examples and requires regular inventory of abusable items. Also has a standard on clinic space (P-26,I) that gives some guidance regarding minimal areas needed.	While NCCHC's standards provide more guidance than the other sets, they still are too general to be useful to administrators in planning and stocking facilities.

System Elements	*ACA (1990)*	*APHA (1986)*
B. Direct Services		
1. Emergency Care	Requires availability of 24-hour/day emergency medical, dental and mental health care as outlined in a written plan (#3-4350,M). Also, access to a licensed hospital required (#3-4332,M) as are first aid kits as needed (#3-4352,NM). "Correctional and other personnel" must be trained in first aid, CPR and other emergency procedures and must respond to emergencies within four minutes (#3-4351,M). States that "designated individuals" specified by the inmate should be notified in case of serious illness or injury (#3-4374, NM) and that there must be written procedures for actions to be taken in the event of an inmate's death (#3-4375,NM).	Requires 24-hour emergency care availability and if the census is over 250, staff on-site 24 hours/day. Health staff must be certified in CPR, first aid and emergency care and all correctional staff must be CPR certified (pp. 15-17). Trained correctional officers must be able to enter inmate living areas within 60 seconds in an emergency (p. 70). Arrangements for secondary care services must be made (pp. 25-26). Notification of next-of-kin and authorities not discussed.
2. Non-Emergency Care		
a. Intake Procedures	States that inmates be medically screened on arrival by health-trained or qualified health personnel (#3-4343,M), that all intrasystem transfers receive a health screening by health-trained or qualified health personnel (#3-4344,M), that a full health appraisal be completed within 14 days after arrival at any facility, (#3-4345,NM), (except that the mental health appraisal can extend to 30 days), and that periodic exams (at least biennially) be conducted (#3-4348,NM). Allows certain data to be collected by health-trained personnel (#3-4346,NM).	Requires intake medical screening with an extensive list of areas to be covered by a "trained medical person" for all inmates on admission, followed by a complete medical examination within 7 days (including a mental health assessment) (pp. 1-6). Specifics additional data collection that should be performed for females (pp. 6-7). Requires annual health evaluation (p. 14).
b. Sick Call	Inmates must be notified on arrival of the system for accessing care (#3-4331,M). Sick call, conducted by qualified personnel, should be held as follows: ADP < 100, 1X/week; ADP 100-300, 3X/week; ADP 300+, 4X/week. If inmate's custody status precludes attendance at sick call, it should be provided in the place of the inmate's detention (#3-4353,NM). Segregated inmates must be visited daily (#3-4246,NM).	Inmates must be informed on arrival of procedures for requesting medical attention. Medical requests must be collected and reviewed daily by trained medical personnel. Inmates must be seen within 24 hours of request. Segregated inmates must be visited daily and seen in the medical area at the request of medical staff (pp. 8-10). Sick call must be conducted at least 5 days per week by MD/DO or NP/PA (p. 11), presumably regardless of facility size.
c. Specialty Services	Requires arrangements with specialists in advance of need (#3-4356,NM) and continuity of care (#3-4330, NM).	Requires arrangements for specialty consultants prior to need (pp. 11-12).

JCAHO (1990)	NCCHC (1987)	Comments
Has a section on emergency services (pp. 61-63) but it applies "only to an organization that represents itself in name or in advertising material as a place where emergency medical care is available to the public." Requires "personnel trained in [CPR] and in the use of emergency medical equipment to be in the facility during all hours of operation" (EA.1.3*).	Mandates a written plan for providing 24-hour emergency care (P-43,E), written agreements with designated hospitals (P-28,I), first aid kits (P-24,I), CPR training for all health staff and correctional officers who work with inmates (P-20,E), other health-related training for COs including first aid (P-19,E) and notification of next-of-kin in case of serious illness, injury or death (P-09,I). In the latter instance, local authorities must be notified also (P-10,I).	The three sets of standards designed for corrections agree in most issues, but differ regarding training requirements as to which staff and how many must be trained in what emergency responses.
Has a section on quality of care that provides some general guidelines for intake, but not specific to corrections (pp. 11-12).	Most comparable to APHA's. Requires immediate receiving screening of all inmates upon entrance to the prison system. Specifies test for TB (P-30,E). A full health assessment (including pelvic exams and Paps for females) must be completed within 7 days and repeated annually (P-32,E). A complete mental health exam-ination is required within 14 days (P-33,E). All data collection must be performed by qualified health professionals.	The three sets of standards designed for corrections all require specific intake procedures, but differ as to the level of staff that can perform them (ACA allows health-trained staff for some functions and the other two require qualified health professionals for all tasks) and the time frame when they must be completed. NCCHC's and APHA's are the most comprehensive and the most similar.
Topic not addressed.	All inmates must be notified on arrival about access to health services (P-31,E). All inmates (including those in segregation) have the opportunity to request medical care daily. Requests are received and acted upon by qualified health personnel (P-34,E). Nurses and/or other qualified health personnel must hold sick call five days a week and a physician must hold clinics as follows: ADP < 200, 3X/week; ADP 200-500, 4X/week; ADP 500+, 5X/week. All care must be provided in a clinical setting (P-35,E). In addition, disciplinary segregation inmates must be visited daily (*P-50,E) and those in administrative segregation must be seen at least 3 times per week by health personnel (P-51,I).	The three sets of standards specific to correctional facilities agree on the issue of notification, but differ as to where sick call may be held, how often it must be held and the level of health staff that must conduct it. APHA's and NCCHC's are the most stringent.
Requires the availability and use of appropriate consultation (QC.1.1.7*).	Requires continuity of care including referral to community resources when indicated (P-42,I).	All four sets of standards are in accord, although none provides much specificity.

System Elements	ACA (1990)	APHA (1986)
d. Infirmary Care	Specifies e.g., an on-call physician, 24-hour health care staff, patients within sight or sound of a staff person, a manual of nursing procedures, separate infirmary record (#3-4354,NM).	States that secondary care services must be available and that infirmaries should meet JCAHO's ambulatory care standards (pp. 25-26).
e. Management of Communicable Disease	Requires facilities to have policies and procedures on "serious and infectious diseases" (#3-4365,NM). Specific policy on AIDS required (#3-4366,NM).	Has a section on communicable diseases that requires quarantine and isolation as needed and contact tracing and testing (pp. 22-23). Also has an appendix that discusses appropriate care and precautions for certain communicable diseases common to correctional facilities (pp. 117-128).
f. Mental Health Care	States that "specifically referred inmates" should have a comprehensive evaluation within 14 days of the date of the referral (#3-4349,NM), that arrangements be made for inmates who are severely disturbed and/or retarded (#3-4367,NM); that such inmates be afforded due process (#3-4368,NM); that there be a policy governing the use of restraints for medical and psychiatric purposes (#3-4362,NM); that psychotropic drugs be ordered by a physician (#3-4342,NM); and that there be a suicide prevention and intervention program (#3-4364,NM).	Has a section on mental health that specifies that diagnostic and therapeutic services be available; that certain services be provided; that special training be conducted for health and correctional staff; that there be a program on suicide prevention; that specific rules be followed if restraints are used; that such care not be imposed; and that mental health staff work to enhance the mental health of the institution (pp.35-46).
g. Dental Care	Beyond intake procedures (see #3-4343, #3-4344 and #3-4345), has a standard on dental care that specifies availability of screening and oral hygiene instruction on intake, a dental exam within 3 months, a charting and treatment priority system and specialty consultation (#3-4347,NM).	Has a section on dental care that requires the availability of comprehensive services; adequate staff, facilities and equipment; a comprehensive exam within 30 days of admission performed by a dentist or hygienist; oral hygiene instruction and supplies; and follow-on care as needed with a goal of preventive care (pp. 47-51).
h. Other Special Needs	Specifies individual treatment plans for inmates requiring close medical supervision (#3-4355,NM); the provision of chronic and convalescent care (#3-4357,NM); prostheses and orthodontic devices when needed (#3-4358,NM); policies governing detoxification (#3-4370,NM); management of chemical dependency (#3-4371,NM) and substance abuse programs (#3-4388,NM); and counseling for pregnant inmates on their options (#3-4387,NM). Does not address any other special needs of women or the role of the medical staff in responding to sexual assaults.	Requires follow-up plans on all medical encounters (pp. 13-14); has a section on drug and alcohol treatment (pp. 19-21); a standard on rape (p. 24); one on the special needs of women (pp. 27-28); a section on services for the chronically ill, frail elderly, or disabled (pp. 29-30) as well as homosexuals (pp. 33-34); and one covering vision and eyewear (pp. 53-55).

JCAHO (1990)	*NCCHC (1987)*	*Comments*
Has a section on infirmary care covering such areas as admission, evaluation and discharge criteria; a physician responsible for care of each patient; an RN on each shift; a plan for emergency services; an in-patient record (pp. 65-66).	Similar to ACA's and JCAHO's except that NCCHC's (P-55,E) is essential for accreditation.	The sets of standards are fairly consistent, except that ACA's do not specify that only a physician can admit or discharge patients, which is required under NCCHC's standards and implied in JCAHO's.
States that appropriate isolation procedures be followed for infirmary patients with suspected or diagnosed communicable diseases (IN.1.7*).	Requires policies and procedures governing care of inmates with communicable disease including isolation when medically indicated (P-54,I).	All four sets are consistent, but fairly general. APHA's and then NCCHC's provide the most commentary.
Not covered in the ambulatory care standards manual. JCAHO has a separate set of standards for mental health facilities.	Requires all inmates to have a mental health evaluation within 14 days of admission and that treatment services and referral sources be available (P-33,E); that care be provided for inmates who are mentally ill or retarded (P-56,I); that correctional staff be trained to recognize and respond to mentally ill, developmentally disabled or suicidal inmates (P-19,E); that specific rules be followed when medical restraints are used (P-60,I); that there be a policy governing the use of forced psychotropic medications (P-70,E); and that there be a suicide prevention plan addressing a variety of issues (P-58,E).	Again, the standards of APHA and NCCHC provide the most specificity and guidance for correctional facilities.
Topic not addressed except in conjunction with radiology services (pp. 57-58).	Beyond intake procedures (see P-30,E and P-32,E) has an essential standard that requires screening, oral hygiene instruction and dental health education for all inmates within 7 days of admission; a dental exam within 30 days of admission performed by a dentist; a system of treatment priorities; use of fluorides and other preventive measures when ordered; and consultation with specialists (P-44,E).	The three sets of standards designed for prisons all require some dental services, but differ as to the extent of services, the time frame for providing them and the level of provider required. APHA's and NCCHC's are the more stringent and provide the most guidance.
Requires care plans for patients (pp. 11-12) and that facilities be handicapped equipped (pp. 33, 35). Other issues not specifically addressed.	Has standards mandating the provision of care to meet special needs (including chronic and convalescent care) and the development of individual treatment plans (P-57,E); care of the physically disabled (P-56,I) including protheses when indicated (P-63,I); the need for protocols governing intoxication and withdrawal (P-52,E) and the management of chemically dependent inmates (P-53,I); the role of health staff in responding to sexual assaults (P-59,I); and counseling (P-61,I) and prenatal care (P-62,E) for pregnant women.	Again, JCAHO's do not specifically address many of the special needs issues. The other three sets of standards all recognize the importance of special needs planning, but differ in their emphasis.

System Elements	ACA (1990)	APHA (1986)
C. Support Services		
1. Laboratory & Radiology	Topic not addressed.	Topic not addressed.
2. Pharmacy	Has a standard on pharmaceuticals that covers some aspects of medication management. Allows pharmacy to be managed by "a resident pharmacist or by health-trained personnel under the supervision of the health authority" (#3-4341,M).	Has a section on pharmacy services that covers many aspects of medication management, but not items such as conditions for drug storage, medication disposal etc. (pp. 95-96).
3. Nutrition	Has a section on food service that requires, among other things, that a dietitian or nutritionist review menus at least annually and a food service supervisor at least quarterly regarding dietary allowances (#3-4297,M); that regular menus and special diets be planned in advance and adhered to (#3-4298,NM); that special diets be provided when prescribed (#3-4299,M); and that food not be used as a disciplinary measure (#3-4301,NM). Food service workers must be free of disease and monitored daily for cleanliness (#3-4303,M).	Intake health information should include dietary needs (p. 2); food should be "wholesome, safe for human consumption, and nutritionally adequate" (p. 68) and food handlers should be trained in safe and sanitary practices (p. 69).
4. Medical Records	Specifies contents of the health record (#3-4376,NM); states that health information is confidential except for that shared with the warden regarding inmates' "medical management, security and ability to participate in programs" (#3-4377,NM); that records or summaries should accompany inmates on transfer and information should be released to community providers with written authorization of the inmate (#3-4378,NM); and that inactive records should be retained (#3-4379,NM).	Has a section on health records that covers same areas as ACA's (except information - sharing with warden) plus requires a single uniform record for all services and specifies a problem oriented medical record system of organization. Also requires standard-ization of the record, legibility of entries and a person in charge (pp. 99-101).
5. Education Services		
a. Staff	Training is required for emergency situations (#3-4351,M), suicide prevention (#3-4364,NM) and medication administration (#3-4341,M). Regular in-service for health professionals is not addressed.	Requires emergency training for health and correctional staff (p. 16). Also states that in-service training (including continuing medical education) for health professionals should be provided and documented (p. 106).
b. Inmates	Has a standard on health education for inmates and lists some suggested topics (#3-4363,NM).	Same as ACA's, but provides more commentary (pp.17-19).

JCAHO (1990)	NCCHC (1987)	Comments
Has separate sections on laboratory services (pp. 53-54 and radiology (pp. 57-59), each of which contains several standards governing these services.	Has one standard (P-27,I) requiring a list of the resources used, the need for procedural manuals, and specifications as to the minimal tests and equipment that must be on-site.	Only JCAHO's standards address these services in any detail.
Has a section on pharmaceutical services that provides some general guidelines on policies and personnel (e.g., a licensed pharmacist required), but does not address administration of medications (pp.49-50).	Has the most extensive standard on pharmaceuticals and their management (P-29,E).	NCCHC's standard covers areas missing in other sets. The three health groups all require a pharmacist to be in charge.
States only that "the direct needs of patients [in the infirmary] are met" (IN.1.8).	Requires an adequate diet based on current RDAs for all inmates, provision of therapeutic diets as prescribed by a physician or dentist, and review of regular and therapeutic menus for nutritional adequacy by a registered dietitian at least every six months (P-46,I). Requires food handlers to be free from disease and monitored daily for cleanliness (P-22,I).	ACA's food service standards are the most comprehensive and JCAHO's the least. The three sets designed for corrections are fairly consistent, although the emphasis given to certain aspects of food handling may differ.
Has a section on medical records that is comparable to APHA's, but more extensive in terms of specific requirements (pp. 15-17). Only area not covered is transfer of record with patient, since these standards were not designed for correctional systems.	Has a section on medical records that covers format and contents (P-64,E), confidentiality (P-65,E), transfer of the medical record (P-66,I) and retention of inactive records including re-activation if an inmate returns to the system (P-67,I). Similar to ACA's in format (since both were based on prior AMA standards), but NCCHC's have more extensive commentary and differ in emphasis (P-64 and P-65 are designated as essential standards for accreditation whereas ACA's are nonmandatory).	There is substantial agreement on most items governing medical records. Except for the issue of transfer of records, JCAHO's are the most specific. ACA's provide the least commentary and direction.
Has a section on educational activities that specifies the need for initial orientation and continuing medical education including emergency training. Documentation required (pp. 37-38). Does not address health-related training of correctional staff.	Has standards mandating initial orientation and at least 12 hours of in-service training annually for all full-time health professionals (P-18,E); one mandating emergency and other health-related training for correctional staff (P-19,E), CPR for all staff (P-20,E); medication administration training for applicable staff (P-21,E); and training in suicide prevention (P-58,E).	NCCHC's and then APHA's standards are the most comprehensive and specific. JCAHO's are good with respect to health staff, but ignore training of correctional staff. ACA's address training of correctional staff, but not health staff.
States only that surgical (SA.1.19*) and infirmary (IN.1.6.9*) patients must receive instruction in follow-up care.	Requires health education for inmates, training in self-care and inoculations as needed. Suggested topic list included (P-41,I).	The three sets for corrections are fairly comparable. None identifies patient education as a priority.

APPENDIX F

SAMPLE MEDICAL CALL PASS

MEDICAL CALL PASS
PONTIAC CORRECTIONAL CENTER

NAME:_____ NUMBER:_____ CELL LOCATION:_____

YOUR APPOINTMENT TIME IS:_____ ON:_____ JOB ASSIGNMENT:_____

OUTPATIENTS		CLINICS		MISCELLANEOUS	
☐ Sick Call	☐ Asthma	☐ Hypertension	☐ X - Ray	☐ Special Instructions	
☐ EKG	☐ Diabetic	☐ Dermatologist	☐ Dietitian	☐ Lab	
☐ Treatment/ Dressing	☐ Orthopedic	☐ TB	☐ Dental	☐ Eye	
	☐ Seizure	☐ Cardiac	☐ Psychologist	☐ Oral Surgery	
☐ Physical Exam	☐ Surgery	☐ Medical Director	☐ Psychiatrist		
☐ Food Handlers	☐ Other/Comments:_____				

We try to see you in a timely manner, however, occasionally emergencies that are unforeseen may cause a delay in your appointment. Your consideration is appreciated. Thanks.

I ACCEPT this pass and AGREE to it. Sign:_____

I REFUSE this pass:_____
Inmate REFUSES this pass and also REFUSES to SIGN refusal.

Witness #1 _____ DATE:_____ TIME:_____ Witness #2:_____ DATE:_____ TIME:_____

Time Inmate DEPARTED Cell/Work:_____ CO:_____
Time Inmate ARRIVED at Hospital:_____ CO:_____
Time Inmate DEPARTED Hospital:_____ CO:_____
Time Inmate ARRIVED at Cell/Work:_____ CO:_____

Copy 1 Inmate records Copy 2 to Hospital security Copy 3 as inmate call pass Authorized By:_____

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MATRIX FOR SPECIAL HEALTH NEEDS

IMPLICATIONS FOR:	CATEGORY			
	SUBHEADING	SUBHEADING	SUBHEADING	SUBHEADING
HOUSING				
PROGRAMMING				
STAFFING MEDICAL				
OTHER				
SPECIALTY SERVICES				
SPECIAL SPACE/ EQUIPMENT				
FISCAL				

APPENDIX H

PSYCHIATRIC CRISIS MANAGEMENT -- UNIT LEVEL, TDCJ

TEXAS DEPARTMENT OF CORRECTIONS

MANUAL OF POLICIES AND PROCEDURES

for Health Services

No. 3-13

Page 1 of 7

Revised 5/90

SUBJECT: PSYCHIATRIC CRISIS MANAGEMENT – UNIT LEVEL

PURPOSE: To provide guidelines for the identification, clinical evaluation, intervention and the use of crisis management on a unit level in the event an inmate exhibits suicidal ideation, suicidal behavior or psychiatrically disturbed behavior.

POLICY: When determined to be clinically appropriate, crisis management of inmates/patients manifesting suicidal or psychiatrically disturbed behaviors will occur in selected infirmaries with 24 hour supervision.

DEFINITION: "Crisis Management" means the confinement of the patient in a controlled, safe environment for the purpose of observing his/her behavior and emotional state to assess the mental disorder, if any, and to prevent destructive or self-destructive behavior.

PROCEDURE:

I. Identification: When a patient verbalizes or exhibits bizarre or suicidal behavior as observed by correctional staff and/or other inmates, or when an patient suspects himself to be experiencing a mental abberation, that patient should be referred to or seek the assistance of the Psychiatric Services staff.

A. In an emergency, when there is an imminent probability of harm to the patient or others, any member of the Health Services clinical staff may place a patient on crisis management status subject to the following:

1. A Health Services staff member immediately notifies a psychiatrist or other physician and informs him/her of the patient's condition and behavior. The physician must evaluate the patient and countersign the order for crisis management within 72 hours, if so ordered.

2. If the physician orders crisis management status for the patient, the nurse or physician assistant enters a written order to that effect into the patient's health record.

3. If crisis management status is ordered, the written order must include the information outlined in III-B-6 below.

4. If crisis management status is not ordered, the physician must make recommendations as to how to treat and manage the patient effectively, and the nurse or physician assistant enters the physician's recommendation into the patient's medical record.

II. Assessment: The examination must be conducted by a psychiatrist. Psychiatric emergencies such as suicidal threats or attempts, self-mutilation or acute psychotic breaks will necessitate an immediate decision by the physician without a comprehensive evaluation being completed. If a psychiatrist or other physician is unavailable or chooses to delegate the evaluation, a psychologist will perform the assessment and the physician will make the determination based on the psychologist's assessment.

III. Monitoring

A. Conditions for use of crisis management:

1. Subject to I-A above, a patient may be placed on crisis management status only when he/she displays symptoms of psychiatric illness or suicidal behavior that, in the opinion of the evaluating physician, do not require his/her immediate transfer to a psychiatric inpatient facility.

2. Crisis management must not be used as punishment, as a substitute for effective treatment, rehabilitation or transfer to a psychiatric inpatient facility; or solely for the convenience of the staff.

3. Emergency placement in crisis management may be initiated by a nurse (RN, LVN) for a time no greater than 1 hour pending an order by a physician.

B. Procedures required to initiate, modify, and terminate crisis management:

1. Subject to I-A above, the placement of a patient on crisis management status is authorized by a physician.

2. No order for crisis management may be enforced for longer than 72 hours. Standing or PRN orders are not valid.

3. All orders for crisis management must state the reason(s) for the crisis management status, a level of observation required (see Attachment A), necessary precautions, and duration of the crisis management status.

4. The patient's crisis management status may be modified or terminated by a physician subject to the following:

a. A psychologist, nurse or physician assistant immediately contacts the psychiatrist or other physician and informs him/her the patient's condition and behavior.

b. The nurse or physician assistant must enter in the patient's health record any modification of previous orders or termination order as directed by the physician.

c. In the event the modification of previous orders places the patient in a higher level of crisis management status, a physician must evaluate the patient and countersign the order within 72 hours.

5. Care of the patient while on crisis management status:

a. Clothing, mattress, and blanket are allowed unless otherwise ordered by a physician. While other items or articles (i.e., belts, shoes, matches, etc.) with which a patient might injure himself must be removed before the inmate is placed on crisis management status.

b. Patient is checked by a nurse or psychiatric/rehabilitation aide as frequently as required by the order of crisis management. Those at maximum crisis management level must be checked every 15 minutes.

c. Regular meals and foods served on appropriate servingware for safety.

d. Daily bathing is made available.

e. Bathroom privileges at least every two hours if no facilities are available in the room.

f. Patients may not smoke while on crisis management status.

6. Instructions for crisis management checklist and related documentation (see Attachments A & B).

a. At the time a patient is secluded for crisis management purposes, an entry must be made in the medical record that includes the following information:

(1) The reason and authority for the seclusion;

(2) The time and date of the seclusion;

(3) What information the patient received as to:

(a) Why he/she is being secluded;
(b) How long he/she is likely to remain in crisis management status;

(c) What behavior is required to release the patient from seclusion;
(d) Legal materials.

i. If an inmate is placed in crisis management and legal materials and/or law library access is denied, the physician ordering crisis management must complete an I-178 (denial of access to legal materials for medical reasons) and route same to the law library supervisor.

ii. If the inmate is placed in crisis management based on a telephone order by a physician and legal materials and/or law library access is denied, the nurse taking the physician's order over the telephone must complete the I-178 and route same to the law library supervisor.

b. A patient admitted to the infirmary area for crisis management purposes is to be considered an inpatient for the duration of treatment within the infirmary. Accordingly, an inpatient record will be developed for this course of treatment. Upon discharge back to general population housing, the physician will complete a discharge summary on a discharge summary form that includes the following information:

(1) Reason for admission.
(2) Summary of important events that occurred while the patient was secluded.
(3) Summary of observational notes from the crisis management checklist.
(4) Medication or other treatment received while secluded.
(5) Reason and authority for the release.
(6) Date and time of release.

c. The Health Services employee receiving the physician's order is responsible for ensuring that a crisis management checklist is marked with the patient's identification data and the time and date of the crisis management order recorded; there after nursing or psychiatric/rehabilitation aides will record the following on the checklist. The precaution level must be indicated.

(1) The behaviors observed during scheduled visual checks by Health Services staff are indicated by placing the code or codes and staff initials on the appropriate time line.
(2) Blank lines are provided for adding behaviors not listed.

(3) It is not necessary to duplicate this information in the progress notes.

d. Any medications given must be noted in the patient's medical record. PRN medications also must be charted in the progress notes by appropriate nursing staff.

e. At any time, additional entries may be made in the medical record to indicate something of importance that occurred while the patient was secluded.

f. After the patient is released from crisis management status, but remains in treatment in an inpatient facility, the observation checklist should be maintained in the patient's inpatient record.

g. When the patient is discharged from the inpatient facility, the checklist should be filed in the patient's inpatient medical record. The Discharge Summary written by the physician should reflect observational data compiled in observation checklists.

IV. Housing

A. Any room or cell used as a crisis management area must have the following:

1. Adequate lighting;

2. No exposed electrical outlets;

3. An observation window through which an observer can see the entire room;

4. Detention screens on the inside of any windows;

5. No fixtures on which a patient can harm himself;

6. Adequate ventilation during warm weather and adequate heat during cold weather.

B. Administrative Segregation and Punitive Segregation cells must not be used for crisis management.

C. A regular cell/room may be used to house inmates on "minimum precaution" crisis management status.

D. If a unit does not have a suitable environment to provide crisis management, the patient must be transferred immediately to an appropriate Psychiatric Inpatient Treatment Facility pursuant to Health Services Policy & Procedure #3-12A, or to a regional medical facility with observation capability.

E. A suicidal inmate should not be placed in an isolated cell/room unless constant supervision can be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the patient should not be isolated.

V. Referral

Referral to a Psychiatric Inpatient Treatment Facility (per Health Services Policy & Procedure #3-12A) must be made if an patient is on maximum crisis management status for two consecutive ordering periods, i.e., two three-day spans.

VI. Each patient who is subject to a crisis management order during any twenty-four hour period under the provisions of this policy must be reported to the Unit Health Authority who is responsible for communicating appropriate, clear, and current information to correctional authorities on the unit.

VII. Intervention

Correctional staff who observe or have knowledge of an patient who plans, is, or has immediately engaged in behavior which is of harm to himself or others shall immediately intervene to prevent, interrupt, or minimize such life-threatening behavior.

A. Correctional staff shall be trained to utilize contemporary methods of suicidal prevention which will include but not be limited to the use of rescue tools and life-saving techniques, such as CPR.

B. As soon as possible, Health Services staff shall be immediately informed of life-threatening behavior or situations so appropriate health intervention can be initiated.

C. Correctional psychiatric/rehabilitation aide staff involved in such prevention/intervention measures shall document fully their actions in the patient's health record.

VIII. Notification

Each patient who engages in a suicidal attempt, parasuicidal behavior, or who successfully commits suicide, shall be reported to the Unit Health Authority, who shall insure that notification is provided to the Unit Warden.

IX. Reporting

All assessments of psychiatric disturbances, suicidal behaviors and successful suicides by patients shall be documented by Health Services staff in the patient's health record.

Proponent: Chief of Professional Services/Psychiatric Services

Approved: 5/7/90
(Date)

Deputy Director for Health Services

Reference: NCCHC Standard P-58, Suicide Prevention (essential)
Texas Department of Corrections Administrative Directive 06.56 (rev.1), Procedures for Handling Inmates Identified as Suicide Risks

ATTACHMENT A
POLICY AND PROCEDURE #3-13

LEVELS OF CRISIS MANAGEMENT OPERATIONALLY
DEFINED BY DEGREE OF OBSERVATION REQUIRED

Minimum precaution: The patient may be housed in a regular infirmary cell or an appropriate cell in his cell-block with direct observation by a Health Services staff member a minimum of once per eight hour shift. A Psychiatric Services clinician evaluates the patient daily, at a minimum, and enters an appropriate progress note in the health record.

Moderate precautions: The patient is housed in an infirmary cell with direct observation by appropriately trained and qualified health services personnel at least two times per shift. The Psychiatric Services clinician evaluates the patient at least once per day, at a minimum, and enters appropriate progress notes in the health record.

Maximum precaution: The patient is housed in an infirmary cell with direct observation by appropriately trained and qualified health services personnel at a minimum of every fifteen minutes. The Psychiatric Services clinician evaluates the patient once each day, at a minimum, and enters appropriate progress notes in the health record.

In the event that a crisis occurs when the Psychiatric Services staff are not present, the duty clinician should be notified.

Policy #3-13
Attachment B
(Front)

TEXAS DEPARTMENT OF CORRECTIONS HEALTH SERVICES

OBSERVATION, SECLUSION OR RESTRAINT CHECKLIST

INMATE'S NAME _____ TDC #: _____ CELL LOCATION: _____

CHECK THE APPROPRIATE TYPE

_____ OBSERVATION—PRECAUTION LEVEL: _____ Min (q 8 hr) _____ Med (q 4 hr) _____ Max (q 15 min)

REASON: _____

_____ SECLUSION—PRECAUTION LEVEL: _____ Min (q 8 hr) _____ Med (q 4 hr) _____ Max (q 15 min)

REASON: _____

_____ RESTRAINT—TYPE: _____ REASON: _____

Observation every 15 minutes with BRP and ROM every 2 hours

TIME AND DATE BEGUN: _____ / _____ DURATION OF ORDER: _____ DATE RENEWED: _____

ON MEDICATIONS? _____ YES _____ NO

ITEMS ALLOWED (CHECK APPROPRIATE BOX)

		ALLOWED	DENIED
_____ undergarments	_____ pillow	Legal Materials	
_____ suicidal blanket	_____ one book	RATIONALE:	
_____ smoking materials	_____ mattress		

CODE EXPLANATION

1. Beating on door / wall
2. Yelling or screaming
3. Crying
4. Cursing
5. Laughing
6. Singing
7. Mumbling incoherently
8. Standing still
9. Walking
10. Lying or sitting
11. Quiet
12. Sleeping
13. Meals served / eaten
14. Fluids served / taken
15. Bath / shower
16. Toilet
17. Smoking
18. Restraints Loosened
19. Range of Motion
20. _____
21. _____

STAFF SIGNATURES / INITIALS

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PRIMARY THERAPIST

_____

PSYCHIATRIST/PHYSICIAN

_____

TIME VISUAL CHECKS MADE ON PATIENT

7 a.m. - 3 p.m.	3 p.m. - 11 p.m.	11 p.m. - 7 a.m.
7:00 _____	3:00 _____	11:00 _____
7:15 _____	3:15 _____	11:15 _____
7:30 _____	3:00 _____	11:30 _____
7:45 _____	3:45 _____	11:45 _____
8:00 _____	4:00 _____	12:00 _____
8:15 _____	4:15 _____	12:15 _____
8:30 _____	4:30 _____	12:30 _____
8:45 _____	4:45 _____	12:45 _____
9:00 _____	5:00 _____	1:00 _____
9:15 _____	5:15 _____	1:15 _____
9:30 _____	5:30 _____	1:30 _____
9:45 _____	5:45 _____	1:45 _____
10:00 _____	6:00 _____	2:00 _____
10:15 _____	6:15 _____	2:15 _____
10:30 _____	6:30 _____	2:30 _____
10:45 _____	6:45 _____	2:45 _____
11:00 _____	7:00 _____	3:00 _____
11:15 _____	7:15 _____	3:15 _____
11:30 _____	7:30 _____	3:30 _____
11:45 _____	7:45 _____	3:45 _____
12:00 _____	8:00 _____	4:00 _____
12:15 _____	8:15 _____	4:15 _____
12:30 _____	8:30 _____	4:30 _____
12:45 _____	8:45 _____	4:45 _____
1:00 _____	9:00 _____	5:00 _____
1:15 _____	9:15 _____	5:15 _____
1:30 _____	9:30 _____	5:30 _____
1:45 _____	9:45 _____	5:45 _____
2:00 _____	10:00 _____	6:00 _____
2:15 _____	10:15 _____	6:15 _____
2:30 _____	10:30 _____	6:30 _____
2:45 _____	10:45 _____	6:45 _____

Code and Signature are required on the above time lines per precaution level.

HS-33 (Rev. 3/89)

S1061/3-30-89

INSTRUCTIONS FOR OBSERVATION, SECLUSION OR RESTRAINT CHECKLIST

I. At the time a patient is placed in observation, seclusion or restraint (OSR), an entry must be made in the medical record that includes the following information:

   A. The reason and authority for the OSR;

   B. The date and time of the OSR;

   C. What information the patient receives as to:

      1. Why he/she is being placed in OSR;
      2. How long he/she is likely to remain in OSR;
      3. What behavior is required for release from OSR.

II. The checklist must be marked with the patient's identification data and the time and date of the OSR order recorded. The behaviors observed during scheduled visual checks are indicated by placing the code or codes and staff initials on the appropriate time line. Blank lines are provided for adding behaviors not listed. It is not necessary to duplicate this information in the progess notes.

III. Any medications given must be noted in the patient's chart. PRN medications also must be charted in the progress notes.

IV. When the patient is released from OSR, an entry must be made in the medical record indicating:

   A. Date and time of release;

   B. Reason and authority for the release;

   C. Summary of any important events that occured while the resident was in OSR.

V. At any time, additional entries may be made in the medical record to indicate something of importance that occurred while patient was in OSR.

VI. After the patient is released from OSR status, the Check List should be filed in the patient's medical record.

VII. No order for observation, seclusion and restraint may be in force for longer than twenty-four (24) hours. Reinstatement of such within any twenty-four (24) hour period requires a physicians' order. Standing or "p.r.n." orders are not valid.

LEGEND:

OSR - observation, seclusion or restraint
q - each
BRP - bathroom privileges
ROM - range of motion

REFERENCES:
Health Services Policy and Procedure #3-13, Psychiatric Crisis Management - Unit Level
Health Services Policy and Procedure #3-28, Use of Medical Restraints, Psychiatric Patients

APPENDIX I

NCCHC's POLICY STATEMENT REGARDING THE ADMINISTRATIVE MANAGEMENT OF INMATES WITH HIV POSITIVE TEST RESULTS OR AIDS

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

2105 N. SOUTHPORT SUITE 200 CHICAGO, ILLINOIS 60614-4017 (312) 528-0818 FAX: (312) 528-4915

Policy Statement Regarding the Administrative Management of Inmates with HIV Positive Test Results or AIDS

The National Commission on Correctional Health Care (NCCHC) is a not-for-profit 501(c)(3) organization whose board of directors is comprised of individuals named by 31 professional associations -- most of which are in the health care field. The Commission's primary purpose is to work toward improving health services in the nation's jails, prisons and juvenile facilities. Toward that end, the Commission has published standards and offers an accreditation award to facilities that meet those standards.

Occasionally, a problem arises that has not been addressed by the Commission's standards. One such issue is the administrative management of HIV positive inmates and those with AIDS (Acquired Immune Deficiency Syndrome). Accordingly, NCCHC has issued the following policy statements to assist correctional facilities in designing their own procedures regarding the administrative management of HIV positive inmates and those with AIDS.

Please note that the Commission's policies do not address the medical management of such patients, since this information is available from other national agencies such as the Centers for Disease Control (CDC) in Atlanta. The Commission's Board of Directors believes that the medical management of inmates should parallel that offered to individuals in the free community. Also note that these policy statements have been approved by the Commission's Board of Directors but do not necessarily reflect the position of the supporting organizations who named those individuals to the Commission's Board.

I. HIV Testing

Testing for HIV is valid as a diagnostic tool. With advances in the diagnosis and treatment of HIV, it is important that those who are seropositive be identified early. Accordingly, voluntary testing for the purpose of initiating

treatment should be available to persons who request it, others with clinical indications of the disease and individuals who engage in high risk behaviors. While recent research has demonstrated that early treatment can delay the progression of the disease, it is not yet clear that large scale screening is efficacious.

II. Special Housing

The Commission does not advocate segregated housing for HIV positive inmates who have no symptoms of the disease. Since the AIDS virus is not airborne and is not spread by casual contact, HIV positive inmates can be maintained in the general population in whatever housing is appropriate for their age, custody class, etc. However, AIDS patients may require medical isolation for their well-being as determined by the treating physician.

III. Special Precautions

Except under unusual circumstances (e.g., the inmate is violent), correctional staff need not take special precautions in managing HIV positive inmates. Masks, gowns, and/or gloves are not required in performing routine duties such as feeding, escorting or transporting HIV positive inmates.

Similarly, medical staff need not take special precautions in performing routine non-invasive procedures on HIV positive inmates such as interviews or examinations. However, for any invasive procedure (e.g., blood drawing, IV placement, draining of abscesses, suturing, excisions, biopsies, dental work), all inmates should be considered potential carriers of HIV and all staff should take precautions as recommended by the CDC. The CDC's recommendations also should be followed in the medical management of AIDS patients.

IV. Confidentiality

Recognizing that being labeled as HIV positive may put an inmate in a correctional institution at undue risk for personal safety, it is particularly important that the rules of physician/patient confidentiality regarding HIV test results and diagnoses of AIDS be followed. Further, since the legal status regarding the confidentiality of such information varies from state to state and from time to time, the facility should keep informed of any changes enacted by legislatures or determined by the courts.

V. Counseling

All HIV positive inmates and those with AIDS should receive counseling to help them adjust to their conditions and to alert them to behavioral changes that may be required to prevent future contagion of others. Additionally, such inmates should be encouraged to voluntarily contact sexual or drug partners and advise them of their (the inmate's) condition.

VI. Prevention

Massive educational efforts should be undertaken to inform all inmates and all staff (correctional and medical) about this disease and the steps to be taken to prevent its spread. Further, while the Commission clearly does not condone illegal activity by inmates, the terminal absoluteness of the disease coupled with the potential for catastrophic epidemia, require (consistent with security) the unorthodox conduct of making available to inmates whatever appropriate protective devices can reduce the risk of contagion.

VII. Special Correctional Programs

HIV positive inmates and those with AIDS who otherwise meet eligibility criteria for special correctional programs (e.g., parole, medical reprieve) should be given the same consideration as are other inmates.

Adopted by the Board of Directors of the National Commission on Correctional Health Care at its annual meeting on November 8, 1987.

Amended: April 30, 1989
April 29, 1990

APPENDIX J

SAMPLE CLINIC/INFIRMARY EQUIPMENT LIST

The following equipment list is suggestive. More or less equipment may be required depending on the special needs and the level of care of a particular facililty. Note also that certain equipment requires special expertise to operate and should not be purchased unless the facility has staff with the requisite training. Also, computer equipment is not included and its use should be considered for several areas.

Conference/training room

Blackboard
Chairs
Conference table
TV-25"
VCR

Dental Lab

Air and natural gas outlets
Alcohol torch
Bunsen burner
Cleaner, utrasonic
Engine, bench w/ handpiece
Lathe w/suction unit, dust hood, light, and safety panel glass for polishing, auto chuck kit
Plaster trap
Receptacle, waste
Spatulas and plastic mixing bowls
Stool, lab
Vibrator

Dental Operatory (each)

Amalgamator (high speed)
*Autoclave
*Air compressor, dental, and buckboost transformer and filter
Cabinet, mobile, dental
*Curing light
Dental chair
Dental lights with adaptor for model of unit ordered
Dental unit w/handpieces (high & low speed, with water syringe & evacuator)
*Emergency kit
Illuminator, x-ray
*Oxygen, portable resuscitator
*Processor, auto,(x-ray)
*Pump, vaccum, dental
Receptacle
Scaler, dental ultrasonic
Stool, dentist
Stool, dental assistant
Syringe and needle disposal (puncture resistant)
*Water softener
*X-ray unit, dental intraoral
*X-ray screen, mobile (depending on construction)
*X-ray apron, patient

* These items listed per dental clinic, not per operatory.

Emergency Room

Ambu bag
Autoclave, OCR
Cabinet, treatment, lockable
Cart, utility
Cast cutter
Cot, ambulance
Crash cart
Diagnostic set
Defibrillator/monitor
Emergency medication box
Eye/face wash, wall mount
Foot stool
Hyfrecator
Kick bucket
Laryngoscope, handle and blades
MAST (trousers)
Mayo stand
Oxygen tank set
O2 cart resuscitator
Receptacle, waste
Scale

Emergency Room (cont'd)

Screen, privacy
Soap dispenser, wall
Sphygmomanometer, mobile
Stool, revolving
Stretcher, scoop
Stretcher, transport, with removable litter and cushion
Stretcher, gurney
Stretcher, emergency
Suction, portable
Surgical light
Syringe destroyer, electric
Table, tilt, treatment, or surgical
Table, instrument, stainless steel
Thermometer, electronic
View box, x-ray
Wheelchair

Eye Examination

Lensometer
Keratometer
Ophthalmic chair
Ophthalmoscope, giant scope 6.5V with case and transformer
Ophthalmoscope, monocular indirect 6.5 V with cradle/instru. transformer
Photometer, reflective
Prisms, set, plastic
Refractor
Retinoscope
Slit-lamp
Spectrophotometer
Trial frame
Trial lens set, full aperture
Vision tester

Infirmary Patient Rooms (each)

Adjustable bed
Bedside cabinet
Call system, patient to nurse
Overbed table
Privacy screen
Safety bedrails

Health records

Letter-size file drawers or special medical chart file cabinets.

Laboratory

Centrifuge, clinical
Centrifuge, micro-hematocrit and tube reader, micro capillary
Counter, lab
Glucometer
Hemacytometer chamber with cover glasses
Incubator, CO2
Microscope, binocular
Refrigerator
Sedimentation apparatus
Staining rack and tray
Syringe destroyer, electric
Urinometer

Offices

All offices should include:

Chair, (executive/secretarial)
Chair, side
Desk, (executive/secretarial)
Bookcase(s)
File cabinet(s)

Pharmacy

Cart, medicine, unit dose
Cart, medicine transfer, unit dose
Heat sealer (for blister packs)
Numbering machine
Reference texts
Refrigerator
Torsion balance

Physical Therapy

Achilles tendon reflex apparatus
Bicycle exerciser
Black light
Diathermy
Electric needle apparatus

Physical Therapy (cont'd)

Electric needle apparatus table 3" x 72"
Emergency oxygen unit
Exercise staircase, straight type
Infrared lamp
Hydrocollator, 12 pack, hot pack mobile unit
Parallel bars
Table, exercise
Treadmill
Ultrasound unit, with stand
Vital capacity apparatus
Wheel, shoulder
Whirlpool bath, stationary (arm, foot, leg, knee)

Radiology

Auto film processor
Bucky holder, upright
Identification printer
Lead apron, coat type
Lead gloves, protective
Lead markers, left and right
Safe light, darkroom
Window, viewing, telescoping, lead-lined
View box, x-ray
x-ray calipers
x-ray storage bin
x-ray film storage cabinet
x-ray table, 76" horizontal
x-ray unit, 300ma

Treatment/Examination Room (each)

Aluminum costumer
Aspirator with mobile stand
Cabinet: instrument; wall; treatment
Cart, SS utility
Diagnostic set, oto-ophthalmoscope, rechargable
Electrocardiograph, with stand, 12 lead
Gooseneck exam light
Peak flow meter
Scale, person weighing, 350 lb. capacity, with measuring rod
Sphygmomanometer (aneroid)
Sphygmomanometer (aneroid, mobile w/base)
Sterilizer, single chamber omni-clave
Surgical light
Table, examining, tilt, and surgical
Table, instrument, stainless steel, 20 x 36 x 36 " high
Thermometer, electronic
Tonometer
View box, (x-ray)

OTHER ASSORTED EQUIPMENT

All emergency rooms and examination and treatment rooms as well as the lab and the pharmacy should have running water with sink and fixtures specified. A water softener system should be considered for special equipment.

Stools (stainless, adjustable), waste buckets, towel and soap dispensers, and special equipment holders should be included in each designated room.

Office equipment (e.g. typewriters, waste baskets, file cabinets, bookcases) should be included. If the system is computerized, the terminal locations should be indicated.

Shelving, file cabinets, etc. should be included for storage areas.

If the health unit is to serve female inmates, an examination table with stirrups will be needed as well.

APPENDIX K

SAMPLE POLICY

QUALITY ASSURANCE PROGRAM - ILLINOIS DOC

04 Programs and Services

03 Medical and Health Care

125A-J Quality Assurance Program

I. POLICY

A. Authority

Ill. Rev. Stat., Ch. 38, Para. 1003-2-2.

B. Policy Statement

Each correctional facility shall be responsible for developing a comprehensive Quality Assurance Program which provides for the systematic, on-going, objective monitoring and evaluation of the quality and appropriateness of patient care. The purpose of the Quality Assurance Program is to pursue opportunities to improve patient care and resolve identified problems in an effort to achieve optimal patient care in a cost-efficient manner.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish written guidelines defining the requirements of the Ouality Assurance Program:

1. To assure high quality patient care is maintained and delivered in a cost-efficient, safe, and appropriate manner.

2. To assure compliance with recognized community standards of care as well as those determined by the American Correctional Association. Compliance with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards for Ambulatory Health Care is optimal. The actual institutional accreditation process shall be determined, where applicable, by the Agency Medical Director in conjunction with Department of Corrections Administration.

3. To assure ongoing, systematic evaluation of patient care practices, professional/clinical performance and patient care services.

B. Applicability

This directive is applicable to all correctional facilities in the Adult and Juvenile Divisions.

04 Programs and Services

03 Medical and Health Care

125A-J Quality Assurance Program

C. Internal Audits

An internal audit of this directive shall be conducted at least annually.

D. Definitions

1. Quality Assurance - the process by which health care delivery is objectively and systematically monitored and evaluated to assess the quality and appropriateness of care and opportunities are pursued to improve patient care as identified problems are resolved.

2. Indicator - a measurable variable relating to the structure, process, or outcome of care.

3. Structure of Care - all inputs into care such as facilities, equipment, resources, or numbers and qualifications of staff.

4. Process of Care - those functions carried out by practitioners, including assessment, planning of treatment, indications for procedures and treatments, and management of complications.

5. Outcome of Care - positive and negative and short and long-term effects on a patient's health and functioning which are attributed to care provided.

6. Monitoring and Evaluation Process - On-going examination of care provided, identification of deficiencies in the services delivered, and improvement of the quality of care as necessary.

7. Assessment - appraisal of a problem or condition.

8. Criteria - predetermined objective elements of patient care used to measure extent, value or quality.

9. Problem - an aspect of health care services about which a question, concern, or deficiency has been identified.

04 Programs and Services

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125A-J Quality Assurance Program

E. Requirements

1. The Chief Administrative Officer shall designate a Quality Assurance Coordinator and shall ensure the Office of Health Services is advised of the name of the Coordinator. The Coordinator shall be the Health Care Unit Administrator, Medical Records Director, the Director of Nursing, or any person who functions in one of these capacities.

2. The Quality Assurance Coordinator shall coordinate the institutional Quality Assurance Program and function as liaison with the Office of Health Services.

3. A table of organization shall be developed at each facility which shall delineate the relationship between institutional health services and the health services governing body. The governing body includes the Chief Administrative Officer, the Office of Health Services and the health service contractor, if applicable, as reflected by the example on Attachment A. While the Chief Administrative Officer has direct, line authority over the administrative aspects of the institutional health delivery system, the institutional Medical Director remains the sole medical authority and is clinically responsible to the Agency Medical Director. The vendor has authority as outlined in the contractual agreement.

4. The Chief Administrative Officer shall establish a Quality Assurance Committee which shall:

   a. Be responsible for annually developing and/or updating a Quality Assurance Plan based on a program which identifies problems and opens channels of communication for appropriate resolution of identified concerns.

      (1) The Plan shall include the program's objectives, organization, scope, and mechanisms for reviewing the effectiveness of the monitoring, evaluation, problem-solving activities, and a schedule of events.

      (2) The plan shall minimally be reviewed and approved by the Chief Administrative Officer and the Agency Medical Director.

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(3) The institutional Medical Director, Health Care Unit Administrator and Quality Assurance Coordinator shall meet no less than annually with the governing body to advise of the Ouality Assurance Plan and other information pertaining to the Ouality Assurance Program.

b. Be composed of at least the institutional Medical Director, Ouality Assurance Coordinator, Health Care Unit Administrator, appropriate Assistant Warden/Superintendent, and Contract Representative, where applicable.

(1) A representative from nursing, medical records, mental health, dental, pharmacy, radiology, laboratory, or other health care disciplines, or security may serve on the Committee and/or attend Committee meetings based on the agenda.

(2) Other clinical, administrative, and support staff may, at the discretion of the institutional Medical Director or Quality Assurance Coordinator, be requested to participate in Committee activities as they relate to identified needs, problems, or other patient care issues.

c. Meet on a regular basis, but not less than monthly. However, smaller facilities (i.e. facilities with a rated capacity of less than 350) may meet every other month.

d. Determine, based on need and the potential degree of the adverse impact on patient care that can be expected if a problem remains unresolved, the frequency/priority status for monitoring activities not specified by this directive.

e. Submit a written summary in the Quality Assurance Committee minutes to the Office of Health Services indicating any changes and/or improvements in providing services as a result of the quality assurance activities. This supplement to the minutes shall be submitted on a quarterly basis for adult facilities and semi-annually for juvenile facilities.

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5. The number of quality assurance activities, frequency of performance, and different organizational entities involved shall follow the guidelines of the Joint Commission on Accreditation of Healthcare Organizations and the Quality Assurance Manual established by the Office of Health Services pertaining to Quality Assurance with additional activity dependent upon real or perceived need.

   a. The activity shall be problem focused and evidenced by documented studies, analytical reports, or other documented, objective methods.

   b. Identified problems shall be prioritized objectively; those with the most serious effects upon patient care shall be dealt with first.

   c. Implementation of actions designed to correct problems shall be instituted through the Quality Assurance Committee with the direct involvement of the service providers and department heads.

   d. Following a reasonable period of implementation, the problem shall be monitored to see if the desired results have been obtained by comparing current outcomes to previous outcomes.

      (1) If the desired results are obtained, the cycle ends. The program area is then routinely monitored as required by this directive.

      (2) If desired results are not obtained, the cycle shall repeat itself to check problem identification, corrective actions, and implementation of corrective actions.

F. Documentation

All quality assurance activities shall be reported to the Quality Assurance Committee and documented in the meeting minutes. Documentation of the monitoring and evaluation process shall minimally include:

1. Problem identification;

2. Monitoring activities;

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3. Assessment;

4. Plan of (corrective) action; and

5. Follow-up.

G. Confidentiality

Copies of minutes, monitoring, and evaluation activities including status reports, inmate complaints, and other related quality assurance data are to be maintained in a strictly confidential manner. The minutes of the Quality Assurance Committee shall be marked "CONFIDENTIAL."

1. Distribution of copies shall be limited to:

   a. Chief Administrative Officer;

   b. Assistant Warden/Superintendent of Programs;

   c. Agency Medical Director;

   d. Corrections Health Care Coordinators, North and South;

   e. Contract Representative, where applicable; and

   f. Health Care Unit Quality Assurance File.

2. To ensure the confidentiality of the minutes, the members and/or attendees of the Quality Assurance Committee meeting shall review the minutes maintained in the Health Care Unit Quality Assurance File and document that review by signature. Members of the health care staff should be advised of relevant quality assurance activities and findings. This may be accomplished by staff review of the minutes on file documented by signature or some other demonstrable mechanism, e.g. minutes of staff meetings, etc.

3. Copies of minutes or access by others is at the discretion of the Medical Director and/or the Health Care Unit Administrator with the approval of the Chief Administrative Officer. Any questions regarding the appropriateness of release of confidential quality assurance materials shall be directed to the Agency Medical Director and Chief of Legal Services for final resolution.

H. Guidelines - Scope of Activities

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b. Identify important aspects of care;

c. Establish objective criteria which reflect the current knowledge and clinical experience of the providers;

d. Collect and organize data;

e. Evaluate care;

f. Develop/implement plan of action to improve care;

g. Assess the effectiveness of the corrective action;

h. Document improvements or changes; and

i. Communicate relevant information to necessary individuals and departments.

2. Quality assurance activities shall include but not be limited to the following activities:

a. Medical Records

A quarterly review of 5% of available medical records, but not less than one or more than 50, shall be monitored and evaluated to assess quality, content, and completeness of documentation.

b. Routine On-Site Patient Care Services

A quarterly review of the quality and appropriateness of 5% of each of the following services, but not less than one or more than 50 cases in each service, shall be conducted:

(1) Sick Call (CMT/LPN, RN, PA-C, MD/DO)

(2) Chronic Clinics

(3) Pharmacy Services/Medication Usage

(4) Therapeutic Diets

(5) Ancillary Services - Laboratory, X-Ray

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(6) Dental Care

(7) Non-emergency Mental Health Services

(8) Specialty Referrals

c. Other On-Site Services

A monthly review of the quality and appropriateness of 100% of the following services shall be conducted:

(1) Emergency Mental Health Services

(2) Infirmary Care

d. Patient Satisfaction

A monthly review of 100% of complaints/grievances by inmates, family members, lawyers, etc. shall be conducted to determine client satisfaction and quality of care.

e. Infection Control

A monthly review of the quality and appropriateness of 100% of the following cases shall be conducted:

(1) Isolation Cases

(2) Communicable Disease Cases Reported to Illinois Department of Public Health

f. Mortality

A monthly review of 100% of mortality cases shall be conducted.

g. New and Delayed Diagnoses

A monthly review of 100% of new or delayed diagnoses (e.g. cancer, myocardial infarction, AIDS, etc.) shall be conducted.

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h. Off-Site Patient Care Services

(1) A monthly review of the quality and appropriateness of care of 100% of the following cases shall be conducted:

(a) Emergency Room Visits

(b) Emergency Admissions

(c) Hospitalizations

(d) Outpatient/Same-Day Surgeries

(2) A monthly review of the quality and appropriateness of care of 5%, but not less than one or more than 50, consultations/referrals/X-rays.

i. Health Care Staff Development

An annual review of the completion of 100% of health care staff training shall be conducted, including:

(1) Pre-service Training

(2) In-service Training

(3) CPR/First-Aid Certification

j. Credentials

An annual review of 100% of all professional credentials of health care staff shall be conducted, including license and privilege sheets, if applicable. More frequent reviews shall be conducted if problems are identified.

k. Safety and Risk Management Activities

A review of the quality and appropriateness of 100% of the following shall be conducted as indicated:

(1) Injury reports for employees and inmates on a monthly basis.

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(2) Disaster and medical emergency preparedness by the month following each drill.

(3) Deficiencies related to health care as indicated in safety and sanitation inspection reports by the month following identification of the deficiency.

(4) Radiologic safety, including radiology badge maintenance, quarterly.

(5) Quality control activities for laboratory, radiology, dental, etc. quarterly.

l. Internal/External Audit Findings

A review of 100% of all audit findings shall be conducted by the month following the receipt of the audit findings.

m. Outcome Studies

A minimum of two different outcome studies per year (one during each six month period) shall be conducted by the Quality Assurance Committee. However, smaller facilities with a rated capacity of less than 350 shall only be required to conduct one outcome study per year.

(1) These studies shall each focus on one particular clinical outcome of care and shall include the identification of a problem or issue, development of criteria describing the clinically acceptable result of treatment, comparison of the clinical data to the criteria, and correction of discrepancies or explanation of individual exceptions to the criteria.

(2) Corrective action shall be initiated as necessary based on the findings of the study. A schedule for re-evaluating the effects of the corrective actions shall be documented.

(3) Each of the steps in the study process shall be fully documented with a concise written summary

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submitted to the Quality Assurance Committee during the month following completion of the study.

NOTE: Quarterly reviews shall be scheduled in a manner which will enable some of the quarterly reviews to be conducted each month.

Authorized by:

DIRECTOR

Supersedes:
04.03.125A-J AD 3/1/89

TABLE OF ORGANIZATION

Relationship of Governing Body to
Institutional Health Services

DIRECTOR

DEPUTY DIRECTOR
Employee & Inmate Services

DEPUTY DIRECTOR
Adult/Juvenile Division

GOVERNING BODY

Agency Medical Director

(Clinical)

Warden or
Superintendent

(Administrative)

Health Services Contractor

(Contractual)

Professional Staff

Assistant Warden
or
Superintendent

Medical Director

(Clinical)

Health Care Unit
Administrator

(Administrative)

Health Services
Operations

APPENDIX L

COST COMPARISON TABLES

TABLE L-1
COMPARISON OF FISCAL YEAR
BY STATE

STATE	FISCAL YEAR
AK	7/1/88-6/30/89B
AZ	7/1/88-6/30/89B
CA	7/1/88-6/30/89B
CO	7/1/88-6/30/89B
DE	7/1/88-6/30/89B
FL	7/1/88-6/30/89B
GA	7/1/88-6/30/89B
ID	7/1/89-6/30/90C
IL	7/1/88-6/30/89B
IA	7/1/88-6/30/89B
KS	7/1/88-6/30/89B
KY	7/1/88-6/30/89B
LA	7/1/88-6/30/89B
ME	7/1/88-6/30/89B
MD	7/1/88-6/30/89B
MN	7/1/88-6/30/89B
MO	7/1/88-6/30/89B
MT	7/1/88-6/30/89B
NE	7/1/88-6/30/89B
NV	7/1/88-6/30/89B
NH	7/1/88-6/30/89B
NJ	7/1/88-6/30/89B
NC	7/1/88-6/30/89B
OH	7/1/88-6/30/89B
OK	7/1/88-6/30/89B
OR	7/1/89-6/30/90C
PA	7/1/88-6/30/89B
RI	7/1/88-6/30/89B
SC	7/1/88-6/30/89B
SD	7/1/88-6/30/89B
TN	7/1/88-6/30/89B
UT	7/1/88-6/30/89B
VA	7/1/88-6/30/89B
WV	7/1/88-6/30/89B
WI	7/1/88-6/30/89B
WY	7/1/88-6/30/89B
TX	9/1/88-8/31/89E
AL	10/1/88-9/30/89A
MI	10/1/88/9/30/89A
FBP	10/1/88-9/30/89A
NY	4/1/89-3/31/90D
AR	7/1/89-6/30/90C
CT	7/1/89-6/30/90C
MA	7/1/89-6/30/90C
NM	7/1/89-6/30/90C
VT	7/1/89-6/30/90C
WA	7/1/89-6/30/90C

N=47

KEY

A = 10/1/88-9/30/89
B = 7/1/88-6/30/89
C = 7/1/89-6/30/90
D = 4/1/89-3/31/90
E = 9/1/88-8/31/89

TABLE L-2
COMPARISON OF 1989 TOTAL DOC
EXPENDITURES IN RANK ORDER BY STATE

STATE†	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION	FISCAL YEAR††	COMMENTS
CA	1,593,256,000	149,660,000	9.4	1,953	76,633	1988-89(B)	
NY	1,094,159,100*	111,799,700*	10.2	2,249	49,711	1989-90(D)	*INCLUDES $30 MIL. FROM MENTAL HEALTH AGENCY
FBP	960,490,600	114,345,162	11.9	2,392	47,804	1988-89(A)	
FL	694,287,968	95,766,619	13.8	2,706	35,386	1988-89(B)	
MI	689,449,480*	75,000,687*	10.9	2,636	28,451	1988-89(A)	*INCLUDES MENTAL HEALTH SECURITY COSTS
OH	688,400,000	39,600,000	5.8	1,366	29,000	1988-89(B)	
TX	508,000,136*	95,838,477*	18.9	2,262	42,365	1988-89(E)	*INCLUDES $16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
IL	437,700,000	34,100,000	7.8	1,570	21,714	1988-89(B)	
NJ	391,574,000	37,364,000	9.5	2,016	18,538	1988-89(B)	
VA	384,733,767	19,500,000	5.1	1,500	13,000	1988-89(B)	
GA	320,763,218	27,404,345	8.5	1,648	16,631	1988-89(B)	
NC	319,888,293	34,747,160	10.9	1,973	17,610	1988-89(B)	
PA	269,913,000	25,235,000	9.3	1,429	17,662	1988-89(B)	
MD	245,514,787	16,713,211	6.8	1,226	13,630	1988-89(B)	
TN	229,628,000	14,427,500	6.3	1,962	7,354	1988-89(B)	
MA	226,450,000*	21,175,000*	9.4	2,379	8,900	1989-90(C)	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
AZ	221,675,400	24,551,201	11.1	1,913	12,836	1988-89(B)	
WA	213,542,450	18,648,840	8.7	2,664	7,000	1989-90(C)	
KS	210,000,000	9,916,000	4.7	1,640	6,048	1988-89(B)	
LA	205,342,717	10,395,142	5.1	831	12,505	1988-89(B)	
CT	195,896,302	18,643,344	9.5	2,108	8,845	1989-90(C)	
SC	183,732,201	19,479,068	10.6	1,387	14,049	1988-89(B)	
MO	166,050,089	11,409,617	6.9	907	12,573	1988-89(B)	
WI	<158,201,700>*	10,800,000*	6.8	1,695	6,373	1988-89(B)	*INCLUDES $2.9 MIL. FOR MENTAL HEALTH SERVICES
OK	142,289,266	9,093,988	6.4	909	10,000	1988-89(B)	
AL	134,888,444	9,493,748	7.0	792	11,990	1988-89(A)	
OR	128,689,876*	10,245,482*	8.0	1,868	5,484	1989-90(C)	*INCLUDES $1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
KY	117,000,000	7,500,000	6.4	1,210	6,200	1988-89(B)	
MN	115,339,305	6,254,049	5.4	2,157	2,900	1988-89(B)	
CO	99,203,000	7,277,599	7.3	1,154	6,306	1988-89(B)	
AK	94,500,000	8,643,000	9.1	3,381	2,556	1988-89(B)	
NM	92,303,300	8,236,800	8.9	2,900	2,840	1989-90(C)	
DE	74,326,900	4,781,100	6.4	1,524	3,138	1988-89(B)	
UT	61,677,566	2,331,752	3.8	1,174	1,986	1988-89(B)	
IA	60,845,599*	4,982,875*	8.2	1,618	3,079	1988-89(B)	*INCLUDES $1,226,987 IN NON-DOC DOLLARS
AR	55,782,785	9,495,347	17.0	1,595	5,954	1989-90(C)	
NV	52,696,523	8,621,933	16.4	1,764	4,887	1988-89(B)	
RI	48,130,805*	3,399,953*	7.1	1,711	1,987	1988-89(B)	*ADULT POPULATION ONLY
NE	44,504,585	4,212,439	9.5	1,795	2,347	1988-89(B)	
SD	36,123,357	1,013,393	2.8	787	1,287	1988-89(B)	
ID	29,797,400	2,847,504	9.6	1,560	1,825	1989-90(C)	
VT	26,000,000	1,387,000	5.3	1,558	890	1989-90(C)	
MT	22,287,160	1,717,927	7.7	1,665	1,032	1988-89(B)	
NH	22,237,822	1,746,660	7.9	1,941	900	1988-89(B)	
WV	21,308,964*	1,603,512*	7.5	1,035	1,550	1988-89(B)	*ADULT POPULATION ONLY
WY	13,961,191	1,122,205	8.0	1,264	888	1988-89(B)	
ME	11,999,372	2,235,135	18.6	1,870	1,195	1988-89(B)	
N=47 AVG:	$257,756,222	$24,569,436	9.5%	$1,906	12,890		

†(NO DATA FOR HI, IN, MS, AND ND); ††KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89. < > = MEDIAN

TABLE L-3
COMPARISON OF 1989 TOTAL CORRECTIONAL HEALTH EXPENDITURES
IN RANK ORDER BY STATE

STATE†	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION	FISCAL YEAR††	COMMENTS
CA	1,593,256,000	149,660,000	9.4	1,953	76,633	1988-89(B)	
FBP	960,490,600	114,345,162	11.9	2,392	47,804	1988-89(A)	
NY	1,094,159,100*	111,799,700*	10.2	2,249	49,711	1989-90(D)	*INCLUDES $30 MIL. FROM MENTAL HEALTH AGENCY
TX	508,000,136*	95,838,477*	18.9	2,262	42,365	1988-89(E)	*INCLUDES $16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
FL	694,287,968	95,766,619	13.8	2,706	35,386	1988-89(B)	
MI	689,449,480*	75,000,687*	10.9	2,636	28,451	1988-89(A)	*INCLUDES MENTAL HEALTH SECURITY COSTS
OH	688,400,000	39,600,000	5.8	1,366	29,000	1988-89(B)	
NJ	391,574,000	37,364,000	9.5	2,016	18,538	1988-89(B)	
NC	319,888,293	34,747,160	10.9	1,973	17,610	1988-89(B)	
IL	437,700,000	34,100,000	7.8	1,570	21,714	1988-89(B)	
GA	320,763,218	27,404,345	8.5	1,648	16,631	1988-89(B)	
PA	269,913,000	25,235,000	9.3	1,429	17,662	1988-89(B)	
AZ	221,675,400	24,551,201	11.1	1,913	12,836	1988-89(B)	
MA	226,450,000*	21,175,000*	9.4	2,379	8,900	1989-90(C)	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
VA	384,733,767	19,500,000	5.1	1,500	13,000	1988-89(B)	
SC	183,732,201	19,479,068	10.6	1,387	14,049	1988-89(B)	
WA	213,542,450	18,648,840	8.7	2,664	7,000	1989-90(C)	
CT	195,896,302	18,643,344	9.5	2,108	8,845	1989-90(C)	
MD	245,514,787	16,713,211	6.8	1,226	13,630	1988-89(B)	
TN	229,628,000	14,427,500	6.3	1,962	7,354	1988-89(B)	
MO	166,050,089	11,409,617	6.9	907	12,573	1988-89(B)	
WI	158,201,700*	10,800,000*	6.8	1,695	6,373	1988-89(B)	*INCLUDES $2.9 MIL. FOR MENTAL HEALTH SERVICE
LA	205,342,717	10,395,142	5.1	831	12,505	1988-89(B)	
OR	128,689,876*	<10,245,482>*	8.0	1,868	5,484	1989-90(C)	*INCLUDES $1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
KS	210,000,000	9,916,000	4.7	1,640	6,048	1988-89(B)	
AR	55,782,785	9,495,347	17.0	1,595	5,954	1989-90(C)	
AL	134,888,444	9,493,748	7.0	792	11,990	1988-89(A)	
OK	142,289,266	9,093,988	6.4	909	10,000	1988-89(B)	
AK	94,500,000	8,643,000	9.1	3,381	2,556	1988-89(B)	
NV	52,696,523	8,621,933	16.4	1,764	4,887	1988-89(B)	
NM	92,303,300	8,236,800	8.9	2,900	2,840	1989-90(C)	
KY	117,000,000	7,500,000	6.4	1,210	6,200	1988-89(B)	
CO	99,203,000	7,277,599	7.3	1,154	6,306	1988-89(B)	
MN	115,339,305	6,254,049	5.4	2,157	2,900	1988-89(B)	
IA	60,845,599*	4,982,875*	8.2	1,618	3,079	1988-89(B)	*INCLUDES $1,226,987 IN NON-DOC DOLLARS
DE	74,326,900	4,781,100	6.4	1,524	3,138	1988-89(B)	
NE	44,504,585	4,212,439	9.5	1,795	2,347	1988-89(B)	
RI	48,130,805*	3,399,953*	7.1	1,711	1,987	1988-89(B)	*ADULT POPULATION ONLY
ID	29,797,400	2,847,504	9.6	1,560	1,825	1989-90(C)	
UT	61,677,566	2,331,752	3.8	1,174	1,986	1988-89(B)	
ME	11,999,372	2,235,135	18.6	1,870	1,195	1988-89(B)	
NH	22,237,822	1,746,660	7.9	1,941	900	1988-89(B)	
MT	22,287,160	1,717,927	7.7	1,665	1,032	1988-89(B)	
WV	21,308,964*	1,603,512*	7.5	1,035	1,550	1988-89(B)	*ADULT POPULATION ONLY
VT	26,000,000	1,387,000	5.3	1,558	890	1989-90(C)	
WY	13,961,191	1,122,205	8.0	1,264	888	1988-89(B)	
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N=47 AVG:	$257,756,222	$24,569,436	9.5%	$1,906	12,890		

†(NO DATA FOR HI, IN, MS, AND ND); ††KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89. < > = MEDIAN

TABLE L-4
COMPARISON OF % OF 1989 TOTAL DOC EXPENDITURES
DEVOTED TO HEALTH IN RANK ORDER BY STATE

STATE†	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION	FISCAL YEAR††	COMMENTS
TX	508,000,136*	95,838,477*	18.9	2,262	42,365	1988-89(E)	*INCLUDES $16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
ME	11,999,372	2,235,135	18.6	1,870	1,195	1988-89(B)	
AR	55,782,785	9,495,347	17.0	1,595	5,954	1989-90(C)	
NV	52,696,523	8,621,933	16.4	1,764	4,887	1988-89(B)	
FL	694,287,968	95,766,619	13.8	2,706	35,386	1988-89(B)	
FBP	960,490,600	114,345,162	11.9	2,392	47,804	1988-89(A)	
AZ	221,675,400	24,551,201	11.1	1,913	12,836	1988-89(B)	
MI	689,449,480*	75,000,687*	10.9	2,636	28,451	1988-89(A)	*INCLUDES MENTAL HEALTH SECURITY COSTS
NC	319,888,293	34,747,160	10.9	1,973	17,610	1988-89(B)	
SC	183,732,201	19,479,068	10.6	1,387	14,049	1988-89(B)	
NY	1,094,159,100*	111,799,700*	10.2	2,249	49,711	1989-90(D)	*INCLUDES $30 MIL. FROM MENTAL HEALTH AGENCY
ID	29,797,400	2,847,504	9.6	1,560	1,825	1989-90(C)	
NJ	391,574,000	37,364,000	9.5	2,016	18,538	1988-89(B)	
CT	195,896,302	18,643,344	9.5	2,108	8,845	1989-90(C)	
NE	44,504,585	4,212,439	9.5	1,795	2,347	1988-89(B)	
CA	1,593,256,000	149,660,000	9.4	1,953	76,633	1988-89(B)	
MA	226,450,000*	21,175,000*	9.4	2,379	8,900	1989-90(C)	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
PA	269,913,000	25,235,000	9.3	1,429	17,662	1988-89(B)	
AK	94,500,000	8,643,000	9.1	3,381	2,556	1988-89(B)	
NM	92,303,300	8,236,800	8.9	2,900	2,840	1989-90(C)	
WA	213,542,450	18,648,840	8.7	2,664	7,000	1989-90(C)	
GA	320,763,218	27,404,345	8.5	1,648	16,631	1988-89(B)	
IA	60,845,599*	4,982,875*	8.2	1,618	3,079	1988-89(B)	*INCLUDES $1,226,987 IN NON-DOC DOLLARS
WY	13,961,191	1,122,205	<8.0>	1,264	888	1988-89(B)	
OR	128,689,876*	10,245,482*	8.0	1,868	5,484	1989-90(C)	*INCLUDES $1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
NH	22,237,822	1,746,660	7.9	1,941	900	1988-89(B)	
IL	437,700,000	34,100,000	7.8	1,570	21,714	1988-89(B)	
MT	22,287,160	1,717,927	7.7	1,665	1,032	1988-89(B)	
WV	21,308,964*	1,603,512*	7.5	1,035	1,550	1988-89(B)	*ADULT POPULATION ONLY
CO	99,203,000	7,277,599	7.3	1,154	6,306	1988-89(B)	
RI	48,130,805*	3,399,953*	7.1	1,711	1,987	1988-89(B)	*ADULT POPULATION ONLY
AL	134,888,444	9,493,748	7.0	792	11,990	1988-89(A)	
MO	166,050,089	11,409,617	6.9	907	12,573	1988-89(B)	
WI	158,201,700*	10,800,000*	6.8	1,695	6,373	1988-89(B)	*INCLUDES $2.9 MIL. FOR MENTAL HEALTH SERVICE
MD	245,514,787	16,713,211	6.8	1,226	13,630	1988-89(B)	
DE	74,326,900	4,781,100	6.4	1,524	3,138	1988-89(B)	
KY	117,000,000	7,500,000	6.4	1,210	6,200	1988-89(B)	
OK	142,289,266	9,093,988	6.4	909	10,000	1988-89(B)	
TN	229,628,000	14,427,500	6.3	1,962	7,354	1988-89(B)	
OH	688,400,000	39,600,000	5.8	1,366	29,000	1988-89(B)	
MN	115,339,305	6,254,049	5.4	2,157	2,900	1988-89(B)	
VT	26,000,000	1,387,000	5.3	1,558	890	1989-90(C)	
VA	384,733,767	19,500,000	5.1	1,500	13,000	1988-89(B)	
LA	205,342,717	10,395,142	5.1	831	12,505	1988-89(B)	
KS	210,000,000	9,916,000	4.7	1,640	6,048	1988-89(B)	
UT	61,677,566	2,331,752	3.8	1,174	1,986	1988-89(B)	
SD	36,123,357	1,013,393	2.8	787	1,287	1988-89(B)	
N=47 AVG:	$257,756,222	$24,569,436	9.5%	$1,906	12,890		

†(NO DATA FOR HI, IN, MS, AND ND); ††KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89. < > = MEDIAN

TABLE L-5
COMPARISON OF 1989 ANNUAL HEALTH COST PER INMATE
IN RANK ORDER BY STATE

STATE†	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION	FISCAL YEAR††	COMMENTS
AK	94,500,000	8,643,000	9.1	3,381	2,556	1988-89(B)	
NM	92,303,300	8,236,800	8.9	2,900	2,840	1989-90(C)	
FL	694,287,968	95,766,619	13.8	2,706	35,386	1988-89(B)	
WA	213,542,450	18,648,840	8.7	2,664	7,000	1989-90(C)	
MI	689,449,480*	75,000,687*	10.9	2,636	28,451	1988-89(A)	*INCLUDES MENTAL HEALTH SECURITY COSTS
FBP	960,490,600	114,345,162	11.9	2,392	47,804	1988-89(A)	
MA	226,450,000*	21,175,000*	9.4	2,379	8,900	1989-90(C)	*ADJUSTED FOR SPECIAL HOSPITALIZATION COSTS
TX	508,000,136*	95,838,477*	18.9	2,262	42,365	1988-89(E)	*INCLUDES $16.25 MIL. FOR OUTSIDE AGENCY HOSPITALIZATION
NY	1,094,159,100*	111,799,700*	10.2	2,249	49,711	1989-90(D)	*INCLUDES $30 MIL. FROM MENTAL HEALTH AGENCY
MN	115,339,305	6,254,049	5.4	2,157	2,900	1988-89(B)	
CT	195,896,302	18,643,344	9.5	2,108	8,845	1989-90(C)	
NJ	391,574,000	37,364,000	9.5	2,016	18,538	1988-89(B)	
NC	319,888,293	34,747,160	10.9	1,973	17,610	1988-89(B)	
TN	229,628,000	14,427,500	6.3	1,962	7,354	1988-89(B)	
CA	1,593,256,000	149,660,000	9.4	1,953	76,633	1988-89(B)	
NH	22,237,822	1,746,660	7.9	1,941	900	1988-89(B)	
AZ	221,675,400	24,551,201	11.1	1,913	12,836	1988-89(B)	
ME	11,999,372	2,235,135	18.6	1,870	1,195	1988-89(B)	
OR	128,689,876*	10,245,482*	8.0	1,868	5,484	1989-90(C)	*INCLUDES $1.85 MIL. FROM OUTSIDE MENTAL HEALTH AGENCY
NE	44,504,585	4,212,439	9.5	1,795	2,347	1988-89(B)	
NV	52,696,523	8,621,933	16.4	1,764	4,887	1988-89(B)	
RI	48,130,805*	3,399,953*	7.1	1,711	1,987	1988-89(B)	*ADULT POPULATION ONLY
WI	158,201,700*	10,800,000*	6.8	1,695	6,373	1988-89(B)	*INCLUDES $2.9 MIL. FOR MENTAL HEALTH SERVICE
MT	22,287,160	1,717,927	7.7	<1,665>	1,032	1988-89(B)	
GA	320,763,218	27,404,345	8.5	1,648	16,631	1988-89(B)	
KS	210,000,000	9,916,000	4.7	1,640	6,048	1988-89(B)	
IA	60,845,599*	4,982,875*	8.2	1,618	3,079	1988-89(B)	*INCLUDES $1,226,987 IN NON-DOC DOLLARS
AR	55,782,785	9,495,347	17.0	1,595	5,954	1989-90(C)	
IL	437,700,000	34,100,000	7.8	1,570	21,714	1988-89(B)	
ID	29,797,400	2,847,504	9.6	1,560	1,825	1989-90(C)	
VT	26,000,000	1,387,000	5.3	1,558	890	1989-90(C)	
DE	74,326,900	4,781,100	6.4	1,524	3,138	1988-89(B)	
VA	384,733,767	19,500,000	5.1	1,500	13,000	1988-89(B)	
PA	269,913,000	25,235,000	9.3	1,429	17,662	1988-89(B)	
SC	183,732,201	19,479,068	10.6	1,387	14,049	1988-89(B)	
OH	688,400,000	39,600,000	5.8	1,366	29,000	1988-89(B)	
WY	13,961,191	1,122,205	8.0	1,264	888	1988-89(B)	
MD	245,514,787	16,713,211	6.8	1,226	13,630	1988-89(B)	
KY	117,000,000	7,500,000	6.4	1,210	6,200	1988-89(B)	
UT	61,677,566	2,331,752	3.8	1,174	1,986	1988-89(B)	
CO	99,203,000	7,277,599	7.3	1,154	6,306	1988-89(B)	
WV	21,308,964*	1,603,512*	7.5	1,035	1,550	1988-89(B)	*ADULT POPULATION ONLY
OK	142,289,266	9,093,988	6.4	909	10,000	1988-89(B)	
MO	166,050,089	11,409,617	6.9	907	12,573	1988-89(B)	
LA	205,342,717	10,395,142	5.1	831	12,505	1988-89(B)	
AL	134,888,444	9,493,748	7.0	792	11,990	1988-89(A)	
SD	36,123,357	1,013,393	2.8	787	1,287	1988-89(B)	
N=47 AVG:	$257,756,222	$24,569,436	9.5%	$1,906	12,890		

†(NO DATA FOR HI, IN, MS, AND ND); ††KEY: A = 10/1/88-9/30/89, B = 7/1/88-6/30/89, C = 7/1/89-6/30/90, D = 4/1/89-3/31/90, E = 9/1/88-8/31/89. < > = median

TABLE L-6
COMPARISON OF CORRECTIONAL HEALTH SERVICE COSTS BY STATE (1982)[1]

STATE†	YEAR	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION
AL	FY 81-82	54,840,532	6,206,750	11.3	1,053	5,892
AK	1982	32,483,584	1,448,239	4.5	1,202	1,205
AZ	FY 81-82	95,028,400	10,532,100	11.1	2,141	4,919
AR	1982	26,900,538	3,423,720	12.7	968	3,536
CA	FY 82-83	548,000,000	39,108,000	7.1	1,171	33,386
CO	1982	47,000,000	3,622,729	7.7	1,249	2,900
CT	1982	N/A	3,000,000	N/A	591	5,075
[illegible]	1982	29,361,400	1,606,600	5.5	857	1,875
GA	FY 81-82	N/A	10,023,822	N/A	919	10,911
HI	FY 82	20,693,921	934,638	4.5	704	1,328
ID	1982	9,743,800	1,005,985	10.3	984	1,022
KS	1982	33,456,926	1,954,041	5.8	706	2,768
LA	FY 81-82	81,839,187	5,627,100	6.9	588	9,570
ME	FY 82	20,942,716	1,051,045	5.0	1,095	960
MD	FY 82	80,814,994	6,307,837	7.8	683	9,233
MN	FY 82	37,848,489	2,098,653	5.5	947	2,215
MS	FY 82	36,853,531	2,403,251	6.5	513	4,685
MO	FY 81	40,000,000	2,800,000	7.0	473	5,918
MT	FY 82	18,217,352	532,718	2.9	710	750
NE	1982	N/A	1,800,000	N/A	1,216	1,480
NH	1982	5,500,000	741,635	13.5	1,648	450
NM	FY 81-82	46,300,000	2,120,000	4.6	1,247	1,700
NC	FY 82	158,064,686	14,867,249	9.4	886	16,786
ND	1982	8,600,000	105,620	1.2	311	340
OK	FY 82	82,391,609	4,670,927	5.7	935	4,996
OR	FY 81	36,244,529	3,003,718	8.3	1,017	2,953
PA	FY 81-82	108,453,000	7,942,000	7.3	836	9,505
RI	FY 82	23,376,931	1,664,830	7.1	1,682	990
SC	FY 82	54,318,609	5,104,866	9.4	593	8,602
SD	1982	6,422,632	358,147	5.6	532	673
TN	FY 81-82	64,535,361	5,044,587	7.8	737	6,842
TX	FY 81-82	264,974,355	12,791,735	4.8	395	32,424
WA	1982	103,864,322	4,875,758	4.7	845	5,771
WI	1982	117,010,700	4,206,253	3.6	919	4,575
WY	1982	12,892,875	382,094	3.0	479	797
FBP	1982	378,007,204	34,856,000	9.2	1,214	28,700
N=36	AVERAGES:	$81,363,096[2]	$5,783,962[3]	7.2%[4]	$883[5]	6,548[6]

†(DOES NOT INCLUDE FL, IL, IN, IA, KY, MA, MI, NV, NJ, NY, OH, UT, VT, VA, WV)

Notes

1. This table was derived from data published by Contact, Inc., VIII Corrections Compendium 2: 5-11 (August, 1983).
2. Average based on the 33 areas with data.
3. Average based on all 36 jurisdictions reporting.
4. Average based on 33 jurisdictions with data in both "Total DOC Expenditure" column and "Total Health Expenditure" column.
5. Weighted average based on all 36 jurisdictions reporting.
6. Average based on all 36 jurisdictions.

TABLE L-7
COMPARISON OF CORRECTIONAL HEALTH SERVICE
COSTS BY STATE (1985)[1]

STATE†	YEAR††	$ TOTAL DOC EXPENDITURE	$ TOTAL HEALTH EXPENDITURE INCLUDING MENTAL HEALTH	% OF TOTAL DOC EXPENDITURE DEVOTED TO HEALTH	$ ANNUAL HEALTH COST PER INMATE	(ADP) TOTAL INMATE POPULATION
AL	1985	102,105,263	9,700,000	9.5	1,239	7,829
AK	FY 85	72,972,973	5,400,000	7.4	2,423	2,229
AZ	1985	140,909,091	9,300,000	6.6	1,269	7,329
AR	1985	38,281,250	4,900,000	12.8	1,072	4,571
CA	1985	N/A	89,000,000	N/A	1,893	47,015
CO	1985	60,317,460	3,800,000	6.3	1,317	2,885
CT	1985	97,727,273	4,300,000	4.4	757	5,680
DE	1985	43,478,261	2,000,000	4.6	1,150	1,739
FL	FY 84	343,902,439	28,200,000	8.2	1,004	28,088
GA	1985	191,208,791	17,400,000	9.1	1,259	13,820
HI	1985	29,850,746	2,000,000	6.7	982	2,037
ID	FY 86	16,853,933	1,500,000	8.9	1,150	1,304
IL	FY 84-85	289,705,882	19,700,000	6.8	1,257	15,672
IN	1985	147,619,048	15,500,000	10.5	1,476	10,501
IA	1985	75,675,676	2,800,000	3.7	576	4,861
KY	FY 83-84	60,465,116	2,600,000	4.3	575	4,522
LA	FY 85-86	110,975,610	9,100,000	8.2	801	11,361
ME	1985	N/A	1,300,000	N/A	1,161	1,120
MD	1985	170,129,870	13,100,000	7.7	1,019	12,856
MA	1985	132,926,829	10,900,000	8.2	1,725	6,319
MN	FY 86	65,822,785	5,200,000	7.9	2,039	2,550
MS	FY 86	48,571,429	3,400,000	7.0	609	5,583
MT	1985	13,515,436	743,349	5.5	772	963
NE	1985	40,000,000	2,200,000	5.5	1,300	1,692
NV	1985	N/A	3,900,000	N/A	1,040	3,750
NH	1985	15,153,846	985,000	6.5	1,448	680
NJ	1985	N/A	10,000,000	N/A	800	12,500
NM	1985	N/A	5,500,000	N/A	2,600	2,115
NY	1985	635,416,667	30,500,000	4.8	901	33,851
NC	1985	216,666,667	23,400,000	10.8	1,398	16,738
ND	1985	5,296,552	307,200	5.8	700	439
OH	1985	N/A	11,100,000	N/A	555	20,000
OK	FY 84	71,084,337	5,900,000	8.3	968	6,095
OR	1985	46,575,342	3,400,000	7.3	1,173	2,899
PA	1985	160,869,565	14,800,000	9.2	1,184	12,500
RI	FY 84-85	27,500,000	2,200,000	8.0	1,762	1,249
SC	1985	97,500,000	3,900,000	4.0	717	5,439
SD	1985	13,157,895	1,000,000	7.6	1,039	962
TN	1985	175,000,000	10,500,000	6.0	1,300	8,077
TX	1985	1,000,000,000	51,000,000	5.1	1,700	30,000
VT	1985	16,486,486	610,000	3.7	1,010	604
WA	FY 85	152,631,579	2,900,000	1.9	461	6,291
WV	1985	18,750,000	1,500,000	8.0	1,014	1,479
WI	1985	N/A	5,400,000	N/A	1,019	5,299
WY	1985	14,057,563	674,763	4.8	800	843
FBP	1985	519,318,182	45,700,000	8.8	1,456	31,387
N=46	AVERAGES:	$140,473,842[2]	$10,852,615[3]	6.8%[4]	$1,230[5]	8,820[6]

†(NOT INCLUDING KS, MI, MO, UT, VA.); ††FIGURES ARE FOR 1985 CALENDAR YEAR UNLESS OTHERWISE NOTED BY FISCAL YEAR

NOTES

1. This table was derived from data published by Contact, Inc., XI Corrections Compendium 1: 7,13-14 (July, 1986).
2. Average based on the 39 areas with data.
3. Average based on all 46 jurisdictions reporting.
4. Average based on 39 jurisdictions with data in both "Total DOC Expenditure" column and "Total Health Expenditure" column.
5. Average based on all 36 jurisdictions. This figure differs from the one reported by Contact, Inc. because here a weighted avereage was used.
6. Average based on all 46 jurisdictions.

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